A STUDY OF THE ROLE OF NASSAU HEALTH CARE CORPORATION IN THE DELIVERY OF HEALTH CARE TO RESIDENTS OF NASSAU COUNTY

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Introduction

The Nassau Health Care Corporation ("NHCC") faces serious financial problems which, if not swiftly addressed, threaten its continued survival. NHCC and Nassau County must move quickly to rethink and restructure NHCC's strategy, operations and finances in order to avoid a financial crisis. If no action is taken, NHCC will collapse of its own weight when it runs out of cash in the next 12-18 months. This restructuring is critical if NHCC is to continue to fulfill its essential role in meeting the health care needs of the residents of Nassau County, particularly the medically indigent, by becoming a first class community hospital, without adding to the financial burden of Nassau County and its taxpayers.

This is the principal conclusion of a study undertaken as a result of the serious concerns that the Nassau County Executive, Thomas Suozzi, the County Comptroller, Howard Weitzman and the Nassau County Legislature had with respect to the governance, management, operations and financial performance of the Nassau Health Care Corporation. This Executive Summary provides an overview of the study, which details NHCC's current financial position, evaluates the origins of its current problems and makes specific recommendations as to what steps need to be taken to stabilize NHCC.

The Current Crisis

The Nassau Health Care Corporation is a public benefit corporation created in September, 1999 under the NYS Public Authorities Law. NHCC is responsible for the operations and finances of the Nassau County Medical Center (whose name was changed to Nassau University Medical Center, "NUMC"), a 631 bed hospital located in East Meadow, New York; Paterson Extended Care Facility ("AHP"), an 889 bed nursing home located in Uniondale, New York, and six health centers and one school health clinic previously operated by the County (the "Diagnostic and Treatment Centers" or "DTCs"), located in Hempstead, Freeport, New Cassel, Elmont, Inwood, and Long Beach, New York. NHCC's total budget for 2004 is estimated to be more than $485 million.

By virtually any measure, NHCC today stands on the brink of financial collapse. The financial facts are easily understood. From its 1999 Bond Issue, NHCC received $135 million in unrestricted cash, and received $22 million from the County for certain capital projects. Since NHCC's establishment as a public benefit corporation in September, 1999 through August 31, 2003, NHCC has received more than $210 million in subsidies and payments from the County, yet NHCC has experienced losses of $91.1 million, as follows:

- NUMC lost $76.4 million;
- AHP lost $13 million; and
- The DTCs lost $900,000, after taking into account $5 million annually in County subsidies for essential public health services.

The prognosis for the future is similarly bleak. In December, 2003, NHCC's Board of Directors and Management adopted a Budget for 2004. NHCC's 2004 Budget forecasts losses in

excess of $35 million, prior to any adjustments intended to reduce the loss. The proposed adjustments include the recently implemented workforce reductions, valued at approximately $18 million, and a variety of initiatives to close the remaining gap. The remaining initiatives appear to be contingent, and may not be achievable. NHCC's CEO has indicated that an additional reduction of 300-400 FTEs may be necessary to achieve a breakeven position in 2004.

Not surprisingly, NHCC's cash position also has deteriorated significantly. On December 31, 1999 NHCC had approximately $140 million of "Cash and Cash Equivalents." As of August, 2003 NHCC had approximately $40 million in "Cash and Cash Equivalents" and the State and County comptrollers and NHCC consultants have predicted a cash crisis by early 2005.

There are a number of contributing factors which have led to NHCC's current predicament. These include:

- Structural flaws in the original framework establishing NHCC which have impeded sound governance and accountability.
- The financial burden imposed by the $256 million in debt assumed by NHCC upon its creation.
- Structural flaws in the Agreements defining the relationship between NHCC and Nassau County.
- The failure of NHCC to fully comprehend its market position and define an appropriate strategic direction.
- The failure of NHCC to manage its operations in a cost-efficient manner.
- General trends affecting all health care providers, including reduced reimbursement, increasing numbers of uninsured patients, increasing labor costs, high cost technological advances, and underfunded pension obligations.

Market Analysis

Any evaluation of the future of NHCC must begin with an understanding of the market served by NHCC and the unique role that NHCC plays in meeting the health care needs of residents of Nassau County. It is apparent that NHCC is the provider of last resort for uninsured and medically vulnerable residents of Nassau County. It is equally apparent that NHCC has failed to implement a strategic business and financial plan based on a realistic assessment of its market position. NHCC has pursued costly, and ultimately unaffordable, initiatives based upon a vision of becoming a full service tertiary care hospital, when in reality it should have structured its operations and programs based upon the goal of being a first class community hospital.

The Demographic and Market Analysis makes clear that the role of NHCC and its three enterprises in the healthcare system in Nassau County is as a provider of basic inpatient, emergency and outpatient care to Nassau County residents, particularly those covered by Medicaid or without insurance coverage. NHCC and its enterprises, although staffed as if they were major components of an academic medical center providing a full range of tertiary care, in fact play the role of a local community hospital that serves as a "safety net" provider to the County's medically indigent.

Specifically, NHCC's hospital, NUMC, provides significant volumes of inpatient and outpatient care in Pediatrics, Psychiatry, Substance Abuse, HIV, Obstetrics and Internal Medicine. NUMC's Emergency Room volumes follow a similar pattern, including a significant role as a "receiving hospital" under Section 9.39 of the New York Mental Hygiene Law, for individuals requiring psychiatric hospitalization. Much of the volume in NUMC's Emergency Room is for primary care, rather than true emergencies.

NUMC's primary care clinics provide similar services, making NUMC, in effect, the family doctor to Nassau County's Medicaid and uninsured population. A similar range of primary care services predominates in NHCC's community health centers or DTCs.

This primary care focus and low patient acuity is reflected in NUMC's case mix index of 1.2, as compared to the much higher case mix index numbers associated with academic medical centers and true tertiary care facilities. While NUMC has numerous specialty clinics, and while NUMC maintains Level I Trauma center designation and operates specialty units (including a Burn Center and Hyperbaric Chamber), the volumes of patients treated in those specialty settings is relatively small, and are not within the core mission of NHCC's hospital and ambulatory care network enterprises.

NHCC's nursing home, the A. Holly Patterson Extended Care Facility, while one of the largest in the United States, similarly serves a low acuity patient population, including hard-to-place individuals who might be able to be placed in other settings. Despite operating several specialty units, AHP's case mix is at or slightly below 1.0, which reflects low acuity and, in some cases, raises the question whether nursing home placement is appropriate.

Strategic Options Considered

Six Strategic Options were considered:

- Option I – Maintain Current Structure and Resolve Disputes. The current structure of the NHCC would be maintained, as would the existing agreements between Nassau County and NHCC. The parties would attempt to resolve existing and future contractual disputes.

- Option II – Closure. Seek to close all or segments of health care services provided by NHCC. This Option could be implemented for all or some of the NHCC enterprises: Acute/Hospital; Nursing Home; and Ambulatory Care.

- Option III – Sale or Transfer. Nassau County and NHCC agree to sell or otherwise transfer all operating certificates, licenses and other assets to other providers, to permit continued operations under new provider ownership.

- Option IV – Management and Professional Services Agreement. Nassau County and NHCC enter into an agreement with another healthcare provider or with a hospital, nursing home or ambulatory care management company, to manage one or more of the licensed facilities and/or to provide professional staffing for NHCC programs.

- Option V – Modify NHCC Enabling Statute and Total Restructuring Of NHCC. Nassau County and NHCC agree to restructuring of the relationship between NHCC and the County, and of the scope of activities of the NHCC enterprises, and necessary

amendments to NHCC's enabling statute would be adopted. Each enterprise would become a subsidiary corporation of NHCC, with its own Board of Directors and its own administrative and medical staff structure. Where appropriate, there could be shared services arrangements among the subsidiaries, based on objective financial benefits. Consistent with the final findings and recommendations, each entity would modify the scope of its programs to reflect its appropriate clinical, educational and research purposes in the context of its role as a provider in the healthcare delivery system in Nassau County. Nassau County's relationship with each subsidiary would be negotiated separately.

- Option VI – Modify NHCC Enabling Statute and Agreements. The contractual arrangement between the County and NHCC would be re-negotiated, to define and quantify the parties' respective obligations, including the debt service obligation, imposition of performance standards, limitation of County payments for care provided by NHCC to the Medicaid rate, and better definition of the nature and scope of services provided by NHCC and payments made by the County. The NHCC enabling legislation would be modified in order to permit the implementation of agreed upon measures to improve operational and cost efficiencies at NHCC (e.g., modification of civil service requirements).

Summary of Recommendations

In order to select among the Strategic Options for NHCC as a whole, and for each NHCC enterprise, the starting point is the role each enterprise plays in delivering services to Nassau County residents, the financial implications of that role, and whether that role could be assumed by others. It is clear from the Market Analysis that the NHCC enterprises fulfill several important roles, for which realistic alternatives do not exist, and therefore, some or all of the NHCC enterprises should continue to exist.

In view of the continuing need for many of NHCC's programs, closure (Strategic Option II) is not recommended. The role NUMC plays is to provide primary and secondary services in Pediatrics, Psychiatry, Substance Abuse, HIV, Obstetrics and Internal Medicine, Emergency Room and Trauma Services, and Ambulatory Care. In each of these areas, as demonstrated by the Market Analysis, NUMC is the major provider of care to Nassau County's residents who are covered by Medicaid or who lack health coverage altogether. If NUMC were to close, care to those populations would be disrupted. Some patients would delay, defer or go without care, rather than finding another provider. The Market Analysis, and interviews with the major healthcare systems in Nassau County, confirm that, in addition to lack of transportation and other accessibility issues, the other providers in Nassau County do not have the capacity to absorb the volumes of Emergency Room, clinic and inpatient care now provided by NUMC.

Continuation of the status quo (Strategic Option I) is not a viable option, given NHCC's likely collapse due to the projected budget shortfalls and cash crisis, and given the documented need to re-focus NHCC's programs on the services most needed by its patients. Similarly Strategic Option VI (Modify Enabling Statute and Agreements) does not provide for the programmatic and structural change required to address NHCC's financial problems. Sale or transfer of NHCC or its enterprises (Strategic Option III) or seeking a Management and Professional Services Agreement (Strategic Option IV) are not viable because potential

purchasers or managers would require resolution of many of the major issues and problems identified in this report prior to assuming responsibility for NHCC or its enterprises.

Consequently, the study recommends Strategic Option V (Modify NHCC Enabling Statute and Total Restructuring of NHCC). This Option provides an approach and framework for restructuring NHCC and its enterprises to provide the appropriate scope of programs to address the health care needs of the Nassau County community it serves, while at the same time working toward financial stability, reduced reliance on County subsidies, and appropriate governance, management and accountability.

Specific Recommendations Relating to Nassau University Medical Center

NUMC's mission, operations and finances should be restructured with the goal of becoming a first class community hospital. The scope of NUMC's current clinical programs and educational and research activities should be changed to conform its programs and costs to its mission as a local community hospital. NUMC has neither the patient volumes nor the level of patient activity to warrant the significant cost of supporting and/or aspiring to become a major academic medical center providing tertiary care services.

Specifically, NUMC should take immediate action as follows:

- Revise its medical program to reflect its principal, high volume, core services, and eliminate or regionalize non-core services.

- Identify, negotiate and execute professional affiliation and support services contracts with one or more of Nassau County's successful health care systems. These agreements should provide the opportunity to regionalize select health care services, provide clinical leadership for specialized health care services and significantly reduce NUMC's physician and related ancillary costs, while at the same time breaking down historic barriers to access to the best health care available in Nassau County for all patients, including the indigent.

- Reduce NUMC staffing to industry standards. After its recent staff reductions, NUMC is staffed at 5.16 FTEs per occupied bed. It should be staffed between 4.6 and 4.8 FTEs per occupied bed.

- Reduce physician staffing and/or modify physician financial arrangements to match the clinical volumes in each clinical department, utilizing appropriate productivity and compensation standards.

- Improve each enterprise's revenue cycle by taking the necessary steps to capture required patient information, accurately document and code medical records, and bill and collect for all services, particularly emergency and ambulatory care services.

- Eliminate or reduce the size of the non-core graduate medical education teaching programs and related attending faculty.

- Participate in Public Health Service Act §340B program. As a public disproportionate share hospital, NUMC is eligible to participate in this statutory program which permits deep discounts on pharmaceuticals.

Specific Recommendations Relating to A. Holly Patterson

With respect to AHP, it is recommended that two options be pursued simultaneously. The first option is to continue AHP as a nursing home, reducing AHP's size to between 450 and 680 beds, and operating its programs in a new facility to be constructed on the NUMC campus in East Meadow. Program configuration, shared services and management and professional affiliations all would be explored as part of this option. The second option to be explored is the closure of AHP, following transfer of AHP's patients to existing voluntary and proprietary nursing homes, which may have the capacity, and have expressed a willingness to accept those patients. The willingness of these providers to enter into appropriate transfer and affiliation agreements, to address a range of concerns (e.g., expedited discharges from NUMC to the nursing homes, indigent care, etc.), and to maintain continuity of care for the patients at NUMC when inpatient care is required, would need to be explored further.

Because each of the two options is subject to further factual investigation and negotiation with outside parties, as well as a number of contingencies, it is recommended that each be pursued and tested simultaneously over the next 18 months. Even if the reconstruction contemplated by the first option is ultimately chosen, pursuit of the second option will have provided greater insight into true extent that other nursing home placements are available, based on capacity at other nursing homes and the actual levels of acuity and other characteristics of AHP's patients. This inquiry will be very helpful in determining whether AHP should be closed, or alternatively, whether it makes sense for NHCC to incur the debt necessary to build a replacement for AHP. It also would provide valuable empirical data for the final sizing of the reconstructed AHP, to meet the need that cannot be met through patient transfers.

Under both of these options, the Uniondale property on which AHP is currently located should be cleared and sold. The proceeds of the sale of the 63 acres of property should be used to reduce or defease the outstanding $256 million debt. Sale of the Uniondale property also would have the salutary effect of returning this site to the local tax rolls, thereby reducing the tax burden on local taxpayers.

Specific Recommendations Relating to Ambulatory Care

The data demonstrates that the NHCC DTCs and OPDs are essential providers of primary care to Nassau County residents, and perform important public health functions for a significant segment of the County's Medicaid and medically indigent population. Consequently, it is recommended that the NHCC DTC and the NUMC clinics continue to operate, but that they should be substantially restructured. In the case of the DTCs, the restructuring should first address operational inefficiencies and lack of productivity, in order to prepare the DTCs to accommodate greater patient volumes. Next, marketing efforts in the relevant communities, and among the NUMC OPD patients should be undertaken to shift much of the primary care volume to the DTCs, as compared to the OPDs. Beyond this immediate strategy, three more initiatives should be considered:

- Conversion of the hospital's primary care clinics to a DTC license and establishment of a DTC site on the NUMC campus.

- Qualification of the NHCC DTC as a Federally Qualified Health Center ("FQHC") look-alike. As an FQHC, the health center would be eligible for certain benefits

including enhanced Medicaid and Medicare reimbursement rates, and wraparound payments with respect to Medicaid managed care patients.

- Qualification of the NHCC DTC as an FQHC Grantee, which can only be obtained through a nationally competitive application process. Grantee status provides two additional benefits beyond that of look-alike status: a grant of up to $600,000 per year, and Federal Tort Claims Act malpractice coverage.

Specific Recommendations In Relation to NHCC Governance and Management

The recommendations with respect to governance and management seek to achieve two critical objectives: first, to make NHCC more accountable and responsive to Nassau County elected and appointed officials, who are responsible for ensuring that the health care needs of all Nassau County residents are met and who are the appropriate representatives of the financial guarantor of NHCC's debt; second, to organize, govern, manage and finance each of the three NHCC enterprises more effectively. The recommendations regarding changes in the composition and appointment of the Board of Directors, and several other changes, will require amendments to NHCC's enabling statute by the New York State Legislature. Pending such legislative action, most of the proposed changes can be achieved consensually. Specifically, NHCC should take action to:

- Change the composition and method of appointment for the Board of Directors, to be comprised of the County Commissioners of Health, Mental Health Social Services, a Deputy County Executive, the NHCC President, and 10 others: five appointed by the County Executive directly and five upon recommendation by the County Legislature. The majority of the current Board of 15 members is appointed by the Governor, upon recommendations from State officials. County officials appoint or nominate six members.

- The newly constituted Board of Directors should immediately review the qualifications of senior management, remove approximately 150-200 management level employees from the Civil Service Employees Association ("CSEA") collective bargaining unit, and establish a proper Management Salary and Benefits Compensation Plan.

- Seek to amend the NHCC statute to provide for certain retained powers of the County normally reserved by a sponsor of health care providers.

- Create separate subsidiary corporations for NUMC, AHP and the Ambulatory Care Network. Restructure and strengthen senior and middle management centrally and at each enterprise to reflect their unique corporate, governance, management, financial and regulatory requirements.

- Revise the NHCC Table of Organization to clarify reporting relationships.

- Seek to amend the NHCC statute to permit the creation of an internally administered Civil Service Commission, and to permit establishment of internal policies and procedures pertaining to purchasing goods and services.

- Seek to amend the NHCC statute to explicitly provide that the Nassau County Comptroller has the authority to review, audit and investigate NHCC's financial affairs.

Financial Impact of Proposed Restructuring Plan

The financial implications of the recommendations are detailed in Chapter VIII, to the extent that estimates can be made at this time. Many of the recommendations require further study and analysis in connection with the implementation process before financial estimates can be developed. The recommendations as to which estimates have been made are summarized below, by enterprise. As detailed in Chapter VIII, the time period required to implement each recommendation varies.

NUMC	
Cost Savings	($15.2 – 20.2 million)
Revenue Increases	$5.5 - 14 million
AHP	
Cost Savings	($3.6 - 6.8 million)
Revenue Increases	$9.5 - 14 million
Ambulatory Care Network	
Cost Savings	not defined at present
Revenue Increases	$6.9 – 7.3 million
NHCC – Labor Concessions [1]	
Cost Savings (all enterprises)	($13.9 – 20.7 million)
Total Cost Savings	($32.7 – 47.7 million)
Total Revenue Enhancements	$21.9 – 35.3 million

In addition, once the restructuring of programs, cost savings and revenue increases have been achieved, there may be an opportunity to apply surpluses toward debt reduction.

[1] These figures reflect labor concessions being sought by NHCC's administration. They are described in detail in Chapter VIII.

I. Introduction: Statement Of The Problem; Scope And Objectives Of The Study

This study was undertaken to address the serious concerns that the Nassau County Executive, Thomas Suozzi, the Nassau County Comptroller, Howard Weitzman, and the County Legislature have with respect to the governance, management, operations and financial performance of the Nassau Health Care Corporation ("NHCC"), the public benefit corporation created in 1999 to operate the Nassau County Medical Center, now Nassau University Medical Center ("NUMC" or the "Hospital"); the A. Holly Patterson Extended Care Facility ("AHP" or the "Nursing Home"); and the seven health centers previously operated by the County (the "Diagnostic and Treatment Centers" or "DTCs").

NHCC's total budget for 2004 is in excess of $485 million. NUMC is a 631–bed hospital located in East Meadow, New York. Approximately 48% of NUMC's beds were occupied in 2001, and internal hospital statistics indicate that occupancy at NUMC may be approximately 60% in the first eight months of 2003. NUMC also operates a Level I Trauma Center/Emergency Room, as well as extensive outpatient clinics.

AHP is an 889-bed nursing home located in Uniondale, New York, licensed to provide general nursing home care, and specialty care for AIDS and ventilator dependent patients. Its beds are 74% occupied. Its level of patient acuity is quite low, with significant negative impact on its Medicaid reimbursement.

The DTCs consist of six health centers located in Hempstead, Freeport, New Cassel, Elmont, Inwood and Long Beach, as well as a school health clinic in Roosevelt. Together, these health centers provide approximately 57,000 visits annually. As discussed in detail below, while the DTCs have a favorable reimbursement rate, NHCC has not received the full benefit of this rate because a disproportionate number of primary care clinic visits take place at the Hospital's Outpatient Department, which has a lower reimbursement rate. In addition, the DTCs are staffed to accommodate twice the number of patient visits they currently handle.

The principal concerns expressed when the County commissioned this study were whether NHCC can meet the health care needs of the residents of Nassau County, particularly the medically indigent, without adding to the financial burdens and liabilities of the County and its taxpayers. These concerns were viewed as urgent, given the serious questions raised by the State and County Comptrollers and NHCC's consultants regarding NHCC's financial viability. The key issues and questions, to be addressed in this report, are:

- Scope of County Obligation, if Any
    - What is the County's legal obligation to operate and/or fund healthcare services, particularly for the medically indigent?
    - How should the County fulfill that obligation (if any)?
    - How can the County reduce the cost of fulfilling that mission?
- Should NHCC as a whole, or by enterprise (Acute, SNF, Ambulatory Care) continue to operate healthcare facilities?

- If some or all of these enterprises are to continue, how should they be reorganized to fulfill a defined mission in an efficient and financially viable manner? Specifically, what, if any, changes should be made to address issues of governance, management, operations and finance, including the size of the financial support required to preserve and support NHCC and its operating enterprises as a financially viable public agency?

- If some or all of the enterprises continue, what, if any, relationship should Nassau County have with them, and how should the current relationship be restructured financially, operationally and in terms of oversight and accountability?

- How should Nassau County and NHCC address the financial legacy imposed by the $256 million bond issue and other financial obligations undertaken by the County in connection with the creation of NHCC (e.g., historic borrowings, pension and other employee-related costs), including development of strategies for reducing and extinguishing those obligations over time, and through restructuring of the operations of NHCC, to the extent permitted by law and agreement?

In May 2003, the County Executive issued a Request For Qualifications to conduct this Study, and selected Manatt, Phelps & Phillips, LLP from the entities that responded. Manatt's proposal described a two phase project, in which Phase I would be a study of NHCC and its healthcare operations, its role in the healthcare delivery system in Nassau County, and its relationship with Nassau County. The study included consideration of Strategic Options and development of key findings and recommendations concerning NHCC and its several enterprises. Issues related to provision of healthcare services to prison inmates were separately studied, and resulted in a separate, confidential report, due to pending litigation. Phase II would encompass briefings, presentations and refinement of the recommendations, followed by development of implementation plans for the selected Strategic Option or Options, and conducting the work effort necessary to carry out the implementation plan.

In order to obtain input from the Nassau County community, the County Executive appointed an Advisory Committee. See Exhibit B for a listing of the members of the Advisory Committee. The Advisory Committee performed a critically important role in the study, by providing information, guidance and direction with respect to the various issues, including the project scope, reviewing and commenting on the Demographic and Market Analysis, reviewing and commenting on the Strategic Options, and, finally, providing their views on the Strategic Options. The members of the Advisory Committee were:

Sharon Commissiong, Majority Counsel to the Nassau County Legislature
Aloysius Cuyjet, M.D.
Larry Gottlieb, Chairman of the Board, NHCC
Rosemarie Guercia, M.D.
Donna Kass
Dan McCloy, Senior Legal/Financial Advisor to Peter Schmitt
Scott Rankin, M.D., Nassau County Department of Health
Stephanie Rubino, Office of Legislative Budget Review

Following the Legislature's approval in mid-August 2003 of a contract for Phase I, Manatt assembled a team of attorneys, planners and other consultants with expertise in the various fields relevant to the Study. Project Direction was provided by Manatt partners George Kalkines, Esq. and Jeffrey C. Thrope Esq.

Other study team members included:

Manatt, Phelps & Phillips, LLP

Deborah Bachrach, Esq.
William S. Bernstein, Esq.
Eliot Fishman, Ph.D.
John E. Linville, Esq.
Hal C. Patrick, Esq.
Caryn A. Rosen, Esq.

Other Consultants

David Honig and Kim Harrison (Ambulatory Care Restructuring), American Express Tax & Business Services, Healthcare Services Group
Charles H. Kachmarik, Jr. (Financial Analysis) Salem Solutions LLC.
Carol Riordan, Ph. D. (Physician Staffing Analysis)
Paul Rosenfeld (Nursing Home/Long-Term Care analysis), with the assistance of Loeb & Troper
William Selan (Architectural and Facilities Review) RBSD Architects.

In addition to review of hundreds of documents and the NHCC enabling legislation, extensive interviews were conducted with the Chairman of NCC's Board of Directors, Lawrence C. Gottlieb, and with NHCC's President and CEO, Richard B. Turan, and Chief Financial Officer, Gary E. Bie. Mr. Gottlieb, Mr. Turan, and Mr. Bie were open, candid, and provided full cooperation with the study, including the provision of many documents and other materials. Moreover, Mr. Turan set a tone of cooperation with the NHCC administration, and interviews were conducted with most of the members of NHCC's senior administrators, as well as several clinical Chairs. Additionally, County legislators were consulted in order to obtain their input and insights.

It should be noted that, while the financial crisis at NHCC is paramount, the recommendations set forth in this report are intended to provide strategic program planning direction to NHCC, improve responsiveness and accountability to County officials, improve governance and management of NHCC, and improve financial performance at NHCC.

We wish to thank and acknowledge the important assistance provided by all of the people who assisted in the Study.

II. An Assessment Of Where NHCC Stands Today And How It Got There

A. NHCC's Financial Position

By virtually any measure, NHCC today stands on the brink of financial collapse. The financial facts are easily understood.

Since NHCC's establishment as a public benefit corporation in September 29, 1999 through August 31, 2003, NHCC has experienced losses of $91.1 million.

- NUMC lost $76.4 million;
- AHP lost $13 million; and
- The DTC lost $900,000, after taking into account $5 million annually in County subsidies for essential public health services, and other grants received by the DTCs.

The prognosis for the future is similarly bleak. In December, 2003, NHCC's Board of Directors and Management adopted the NHCC Budget for 2004. Prior to any adjustments intended to reduce the loss, the 2004 budget forecasts losses in excess of $35 million. The proposed adjustments include the recently implemented workforce reductions valued at approximately $18 million and a variety of initiatives to close the remaining gap. These initiatives include labor concessions being sought by NHCC's management in negotiations for a new Union Contract. They appear to be contingent, and may not be achievable. NHCC's CEO has indicated that an additional reduction of 300-400 FTEs may be necessary to achieve a breakeven position in 2004.

Not surprisingly, NHCC's cash position has also significantly deteriorated. On December 31, 1999 NHCC had approximately $140 million of "Cash and Cash Equivalents." As of August, 2003, NHCC had approximately $40 million in "Cash and Cash Equivalents" and the State and County Comptrollers and NHCC consultants all predicted a cash crisis by early 2005.

B. Role of Nassau County in Supporting NHCC

What is also readily apparent with respect to NHCC's financial position is that it has received enormous financial subsidies and credit support from Nassau County which have enabled it to survive to date. As described below, these subsidies have been provided through a variety of vehicles.

- Simultaneous with the transfer of the hospital, nursing home and clinics from Nassau County to NHCC, a $256 million tax-exempt bond borrowing occurred (the "Bond Issue"). NHCC undertook the primary debt service obligation, with a guarantee running from the County to the bondholders. The true cost of this borrowing, over its 30-year life, is in excess of $470 million. From the bond issue, NHCC received $135 million in unrestricted cash, and received $22 million from the County for certain capital projects. This cash was used by NHCC to cover the operating deficits it generated over the past four years.

- At the time of the establishment of NHCC, NHCC and Nassau County entered into an "Acquisition Agreement" and certain "Service Agreements." Under the terms of these agreements, Nassau County has made payments to NHCC over the past four years totaling more than $210 million. The annual amounts have ranged between $52 and

$53 million, exclusive of the County's share of the cost of Medicaid: $13 million annually as so-called "mission" payments and $39 million annually for services provided by NHCC to Nassau County.

- Nassau County has provided cash flow relief to NHCC through the payment of a quarterly advance against NHCC's billings to the County for services under the Acquisition Agreement and Services Agreement.

As important as Nassau County's financial support has been to NHCC's past survival, this level of financial support is by no means guaranteed in the future. In fact, a review of the history leading to creation of NHCC makes it clear that a principal objective of the county in forming the NHCC was to create an efficient health care delivery system. As stated in the Bill Memorandum accompanying the Legislation creating NHCC, "the County will benefit from [NHCC's] ability to manage its own affairs in a cost effective manner" and NHCC "is projected to provide long term savings to Nassau County." Nassau County has no constitutional or statutory mandate to directly provide healthcare services, except for a small number of specific obligations that would apply to any county, including: providing for healthcare services to inmates in the County correctional facility; and providing certain public health services, in the areas of infection control, disease prevention and immunization.

Consequently, from the perspective of the County, the key question that must be asked and answered today is: What went wrong and can the problem be fixed? Before reviewing the strategic options available to the County and NHCC, it is instructive to assess the factors which have contributed to NHCC's current predicament. Only through defining, and building consensus among key stakeholders, as to what went wrong, can we hope to fashion a workable plan for the future.

C. Factors Contributing to NHCC's Current Predicament

There are a number of contributing factors which have led to NHCC's current predicament. These include:

- Structural flaws in the original framework establishing NHCC which have impeded sound governance and accountability.

- The financial burden imposed by the $256 million in debt assumed by NHCC upon its creation.

- Structural flaws in the agreements defining the relationship between NHCC and Nassau County.

- NHCC's failure to adequately understand its market position and to define an appropriate strategic direction.

- NHCC's failure to manage its operations in a cost-efficient manner and to take advantage of opportunities to maximize revenue and decrease cost.

- General trends affecting all health care providers, including reduced reimbursement, increasing numbers of uninsured patients, increasing labor costs, high cost technological advances and underfunded pension obligations.

1. Structural Flaws Related to the Establishment of NHCC

The enabling legislation for creation of NHCC as a New York Public Benefit Corporation became effective February 6, 1997. Article 10-C Title 2 of the New York Public Authorities Law. NHCC actually came into existence in 1999, and assumed the operation of NUMC, AHP, and the DTCs in September 1999. As a Public Benefit Corporation, NHCC is a "state board" (Public Authorities Law §3402(1)). NHCC is a separate, independent legal entity. The County Executive and majority and minority leaders of the County Legislature have the authority to nominate or appoint a total of six of the 15 members of NHCC's Board of Directors. The County Executive also has the authority to select one of the directors to serve as Chairman of the Board, and has an approval right with respect to the Chief Executive Officer selected by the Board. There is no statutory provision for audit by the County Comptroller.

According to the statute and its legislative history, the purpose for the creation of NHCC as a public benefit corporation was to permit NHCC to assume responsibility for operating the County's extensive health care facilities; to manage and operate those health care programs more efficiently through independent, dedicated governance; and to achieve added management flexibility, so that the facilities making up NHCC could be better positioned to operate in a changed health care environment. All these advantages were expected to result in cost savings to Nassau County.

Based on the study described in this report, we have concluded that none of these contemplated objectives have been realized. All that has occurred is the transfer of the County's pre-NHCC hospital, nursing home and ambulatory care operations to a new State public authority charged with performing an essentially local function. At the same time, the County retains local health care policy responsibility, and significant financial exposure. Yet, as a new State public authority, NHCC was not established in a way that would be responsive and accountable to local officials.

Apart from the County's role in nominating and appointing a minority of directors, designating the Chairman of the Board, and approving the CEO, the NHCC enabling statute makes no provision for financial review or oversight of NHCC by County officials, or for reservation of powers by the County, as described in more detail in Chapter XI, below. Thus, NHCC was permitted to expend the $135 million proceeds of the Bond Issue, without any control by the County, the Nassau Interim Finance Authority or any State Agency, and without the regulatory agreements and formal requisition process normally imposed by State agencies in tax-exempt borrowings by health care providers. Additionally, the NHCC enabling statute does not provide any relief from the historic limitations imposed on local county governments, such as civil service and other restrictions that have impeded accomplishment of the legislation's stated goals.

A detailed discussion of suggested changes to the NHCC enabling statute is set forth in Chapter XI of this Report.

2. Legacy of the 1999 $256 Million Bond Issue

The $256 Million Bond Issue which accompanied the establishment of NHCC masked many of the serious financial issues faced by NHCC and placed upon the institution significant, and unaffordable, ongoing debt service obligations.

The proceeds from the $256 Million Bond Issue were used for several principal purposes: $82 million was paid to Nassau County, and characterized as payment for the sale of hospital, nursing home and clinic assets to NHCC. These funds were used to satisfy Nassau County's deficit; $135 million was provided to NHCC as unrestricted cash; and the remaining funds were devoted to transaction costs and the funding of a debt service reserve fund equal to one year's debt service.

The $256 Million Bond Issue has contributed to NHCC's financial woes in a number of ways. First, from the start it is clear that NHCC did not have the creditworthiness to take on the debt associated with the Bond Issue. The Bond Issue was guaranteed by the County itself and consequently, there was no need at the time for investors to be overly concerned with the capacity of NHCC to meet its debt service obligations.

Second, the use of proceeds from the Bond Issue was highly unusual: instead of being used for capital improvements tied to creation of long term value and therefore reimbursed by third party payors, almost all of the proceeds were used to solve short term cash problems of the County and NHCC, for which third party reimbursement is not available. In effect, the Bond Issue created a financial cushion which allowed NHCC to avoid getting its financial house in order. Finally, the Bond Issue saddled NHCC with a significant ongoing annual cash requirement that will significantly impair NHCC's future operations. The annual debt service obligation for this borrowing is $14.3 million until 2005, and then $19.2 million through 2028.[2]

3. Structural Flaws in the Contractual Relationship Between NHCC and Nassau County

Compounding the effects of the Bond Issue on the financial viability of NHCC is the fact that the Acquisition Agreement and Services Agreements between NHCC and Nassau County have created an adversarial relationship rather than a symbiotic one. The underlying problem is twofold: Nassau County provides significant annual financial support to NHCC, but has never been granted the customary controls necessary to enforce its rights under these agreements and to ensure that it is getting the value to which it is entitled. Finally, the Agreements are poorly drafted and do not adequately describe the obligations, rights and remedies of the parties.

Furthermore, there are serious questions concerning the enforceability of the Acquisition and Services Agreements. While a detailed legal analysis is beyond the scope of this report, these questions arise from the Agreements' lack of adequate definitions of terms, services and compensation arrangements, and the delegation of non-delegable legislative functions. Based upon our interviews with both Nassau County and NHCC representatives, we believe there is a general acknowledgment that the current legal and contractual framework governing their relationship is flawed and must be substantially changed.

[2] During our fact-finding, many individuals referred to NHCC has having been the victim of the 1999 Bond financing, when compared to Westchester County's transfer of its health care facilities to its newly formed public benefit corporation for $1.00. This comparison is inapt, since NHCC was in fact a significant beneficiary of the borrowing. In addition, comparisons to approaches used by other Counties are not dispositive, given the lack of comparability among the rural, suburban and urban areas of the State, and the highly variable nature of the local healthcare delivery systems. The need for municipal provision of healthcare derives largely from deficiencies in the scope of coverage provided by the local for-profit and not-for-profit providers, as well as State, local and Federal hospitals.

4. Lack of Strategic Direction and Understanding of Market Position

While the organizational and financial arrangements surrounding the establishment of NHCC certainly contributed to its current predicament, a far more significant problem is that, from its inception, NHCC failed to understand its market position, and to develop and implement a sound business and financial plan. Consequently, NHCC pursued a costly strategy to position itself as an academic medical center providing tertiary care, a strategy which had little chance of success.

NHCC's failure to appreciate its role and mission in relation to the community it services, and its relative role in the Nassau County health care market, resulted in a failed vision, developed without a reality-based analysis of NHCC's role and mission as a public provider of "safety net" care. Some key facts as to NHCC's market position are as follows:

- NUMC draws more than 60% of its inpatient admissions from six zip codes. These six zip codes are comprised of largely minority populations, with 36.7% of their residents being Black or African American, 7.4% being of Asian origin and 23.9% being of Hispanic or Latino origin.

- NUMC is by far the largest provider of Medicaid inpatient services in Nassau County with Medicaid paying for 10,600 out of 19,000 discharges in 2002. NUMC is also the dominant provider of Emergency Room visits to Medicaid and uninsured patients in Nassau County.

- NUMC has low occupancy rates, low case-mix (a measure of severity of patients' illness that is tied to revenues per patient) and a low market share in surgical services and general inpatient medical services. In contrast, NUMC delivers more than 20% of all Nassau County inpatient pediatric, psychiatric and substance abuse services, more than 40% of inpatient HIV treatment, and more than 60% of the treatment of burns.

While a more complete market assessment is provided in Chapter III and Exhibit E, the conclusion is clear: NHCC enterprises have central importance in Nassau County, but in limited roles as providers of last resort for primary care, hospital and nursing home services to Medicaid and uninsured patients.

This lack of definition of NHCC's services and mission had a significant negative impact, in that NHCC pursued initiatives based on the concept that NUMC would become a freestanding, full service tertiary care hospital. These concepts and initiatives ignored the primary care, community hospital role that is NHCC's realistic core mission. Significant capital and operating dollars were spent seeking to position NHCC as a true competitor to the more advanced providers in Nassau, with regard to the full range of care, including tertiary care. Not only was this vision unrealistic, but it ran counter to the approach of the other providers, who during this period were consolidating into true networks to achieve the efficiencies and cost savings associated with regionalization of specialty services.

NHCC's failure to become a major tertiary hospital is clearly evidenced by its occupancy rates: 48% of NUMC's licensed beds were occupied in 2001, the lowest rate of any hospital currently operating in Nassau County. Occupancy rates at other Nassau hospitals ranged from 54% to 115% of capacity; only two were below 66% of capacity. NHCC's nursing home - - A Holly Paterson - - also suffers from low case-mix and low occupancy rates, with 2001 occupancy

just under 85% - - an extraordinarily low percentage in the nursing home industry. Internal NUMC data indicates that occupancy rates are up to about 60% in the first eight months of 2003, still far lower than almost all Nassau County hospitals.

5. The Failure to Manage Operations in a Cost-Efficient Manner

A direct result of NHCC's lack of strategic direction and misconceptions regarding its role and mission in the Nassau County market is that it has managed its operations in an inappropriate and costly manner. As detailed more fully in Chapter V, there are multiple examples of waste and inefficiency, including:

- Supporting non-core, underutilized programs, such as Neurosurgery, Otolaryngology, Opthamology, Oral Surgery, Orthopedics, Plastic Surgery, Thoracic Surgery, Vascular Surgery, Cardiac Surgery, Invasive Cardiology and Burns.[3]

- Supporting inappropriate physician staffing arrangements which fall well below industry established productivity standards.

While much of NHCC's failure to operate efficiently is related to misconceptions related to its strategic plan, our interviews with key stakeholders also led us to include that lack of strategic direction has not been the sole cause of NHCC's operating issues. Pre- and post-1999, "political" considerations have intruded on both the governance and management of NHCC, engendering divided loyalties and spheres of influence on the Board, and corresponding divisions within NHCC's administration. Any effective reorganization plan for NHCC will need to address this issue head on and ensure that NHCC is guided in the future by a professional management, reporting to a Board with clearly defined fiduciary and legal responsibilities.

6. General Trends Affecting Health Care Providers

While much of NHCC's problems are of their own making, their predicament has been compounded by the difficult environment faced by all health care providers in New York State. Health care providers have been subject to declining reimbursement for their services, while at the same time paying increased labor costs and treating growing numbers of uninsured patients. Additionally, the economic downturn which occurred between early 2000 and 2002 resulted in investment losses and an underfunding of the State pension funds that cover NHCC's employees. NHCC's financial position certainly has been negatively affected by this difficult operating environment. That said, many health care providers have been able to respond to these environmental factors, and there is no reason to believe that NHCC could not do the same.

[3] Due to the historic importance of the burn unit, further analysis and consideration should be given to potential restructuring, regionalization, and/or fund raising for this important service.

III. NHCC's Role: An Overview of the Demographic and Market Analysis

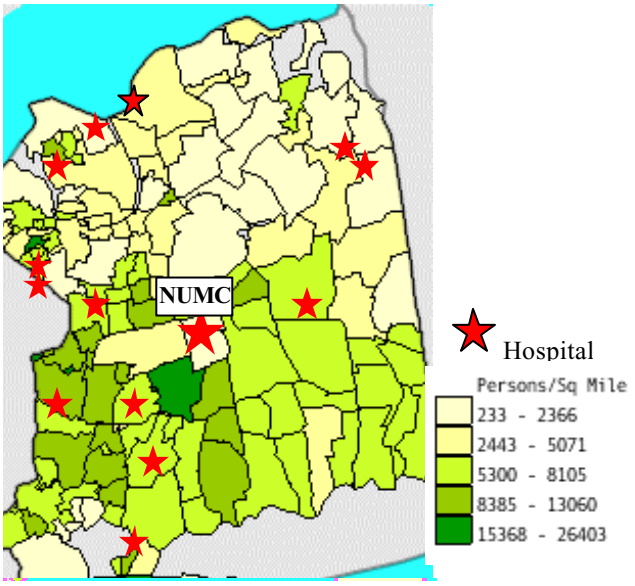
A. Summary of Analysis

Introduction

This section summarizes the Demographic and Market Analysis performed as part of the Study. The complete Demographic and Market Analysis is contained in Exhibit E. As described below, NHCC enterprises have central importance in Nassau County, but in limited roles: as providers of last resort for primary care, hospital and nursing home services to Medicaid and uninsured patients. Most patients with choices, however, choose to use other providers.

However, because of its geographic location, Nassau University Medical Center also serves a broader population as a local community hospital and as a regional emergency department. Although NUMC is located at the geographical and population center of the County, 10 of the other 13 hospitals located in or immediately adjacent to Nassau County are to its west, with the three hospitals to the east of NUMC relatively small. NUMC is the only Level I Trauma Center accessible to the Meadowbrook and Southern State Parkways, and the only Level I or Level II Trauma Center in all of eastern and central Nassau County.

NUMC is at the center of Nassau both in terms of geography and population, but is one of only 4 hospitals in central and eastern Nassau

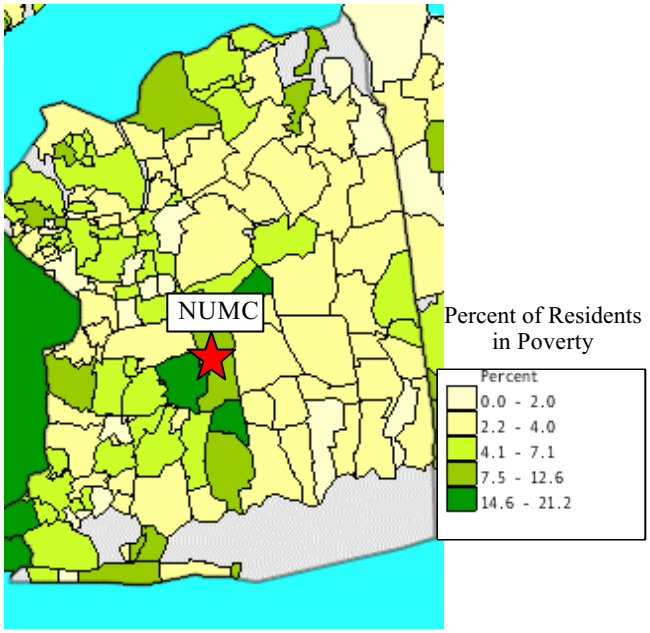


Demographics

Nassau County has the highest median income of any county in New York State, and it is almost 80 percent white. However, Nassau County's low-income population is concentrated in Hempstead, Freeport, and surrounding communities – the area where NUMC is situated.

Nassau County's African American and Hispanic populations are also growing quickly and are also heavily concentrated around NUMC: the six zip codes that are the source of more than 60% of NUMC's inpatient admissions have much larger minority populations than

NUMC is located in the poorest part of Nassau County



Nassau County as a whole, as indicated in the table below.

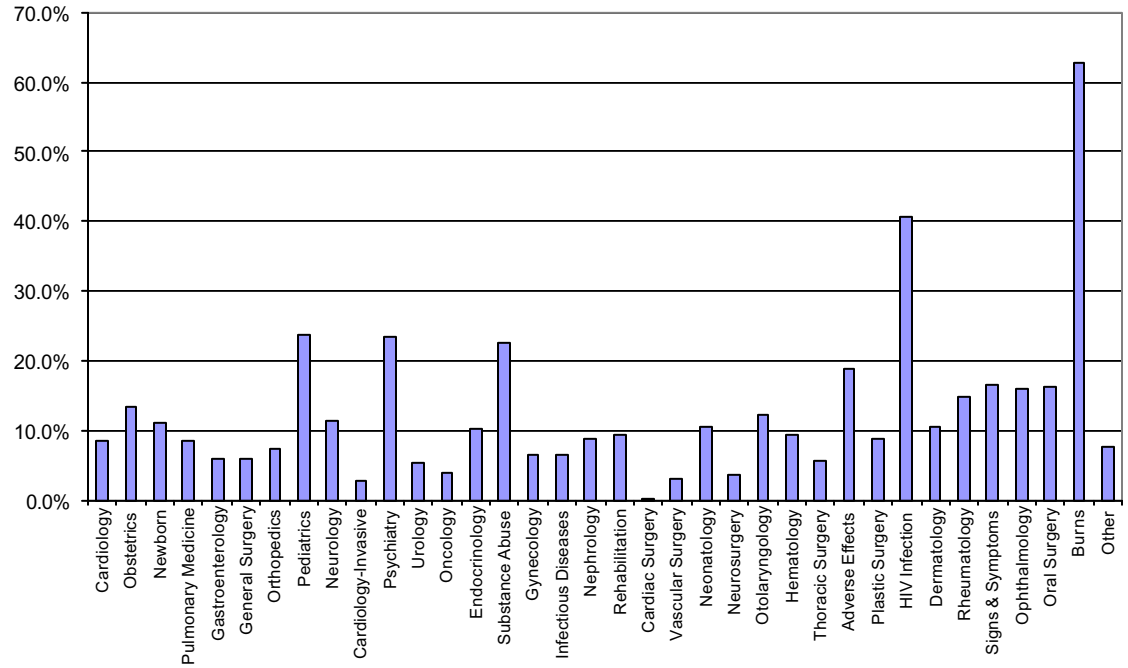
Nassau County Population Ethnic Distribution	White persons, percent, 2000 (a)	Black or African American persons, percent, 2000 (a)	Asian persons, percent, 2000 (a)	Persons of Hispanic or Latino origin, percent, 2000 (b)
Nassau County	79.3%	10.1%	4.7%	10.0%
New York State	67.9%	15.9%	5.5%	15.1%
NUMC Zip Codes	45.0%	36.7%	7.4%	23.9%
(a) Includes persons reporting only one race.	(b) Hispanics may be of any race.		Source: US Census Bureau	

Inpatient Services.

NUMC Hospital has low occupancy rates, low case-mix (a measure of severity of patients' illnesses that dictates revenues per patient) and low market share in surgical services and in general inpatient medical services. When occupancy rates and market share are more closely analyzed, a clear profile of NUMC emerges: more heavily utilized services are typical of a community hospital with a low-income patient base, while NUMC has a marginal presence in most of the more specialized services typical of a tertiary care hospital.

NUMC represented 10% of hospital utilization by Nassau County residents in 2002. When inpatient market share is broken out by medical service, NUMC has low market share in general medicine/surgical discharges—NUMC's share has fluctuated between 5% and 6% in the last four years. Market share in specific surgical services is marginal, except in surgeries related to traumas. In contrast, NUMC delivers more than 20% of all Nassau County inpatient pediatric, psychiatric and substance abuse services, more than 40% of inpatient HIV treatment, and more than 60% of acute treatment of burns.

NUMC Market Share by Service, 2002



48% of NUMC's licensed beds were occupied in 2001, the lowest rate of any hospital currently operating in Nassau County. (Internal NUMC data indicates that occupancy rates are up to about 60% in the first eight months of 2003, still far lower than almost all Nassau County hospitals.) Occupancy rates at other Nassau hospitals ranged from 54% to 115% of capacity; only two were below 66% of capacity. Within these occupancy figures, the following NUMC services were more heavily utilized:

- Psychiatry, with an occupancy rate of 90%
- Inpatient Rehabilitation, with an occupancy rate of 80%
- Maternity, with an occupancy rate of 66%

NUMC depends heavily on low-income patients and on admissions through its emergency room. NUMC is by far the largest provider of Medicaid inpatient services in Nassau County. Medicaid/Medicaid Managed Care is also the dominant payor for NUMC—10,600 out of 19,000 discharges in 2002. 81% of admissions to NUMC come through the emergency room, compared to 42% at North Shore/Manhasset and 41% at LIJ, the second and third most active ERs in the County.

Emergency Services

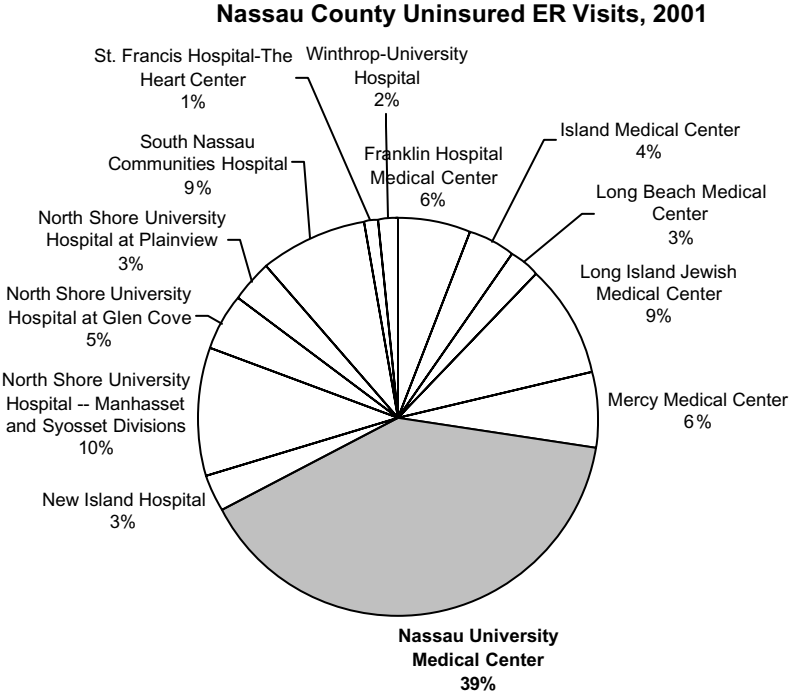
More visits are made to NUMC's Emergency Department than to any other in the County. NUMC provided about one in every six emergency room visits in Nassau County in 2001, a figure that is down slightly from 1999. This volume represents both treatment of traumas and other medical emergencies for much of Nassau County's population, and inappropriate usage of the ER for primary care by low-income patients.

Emergency Room Volumes in Nassau County's Three Largest ERs, 2002	
NUMC	82,111 visits
North Shore-Manhasset	72,366 visits
Long Island Jewish	58,859 visits

For more than half of the population of Nassau, NUMC is the closest emergency room for treatment of traumatic injuries. NUMC is the only Level I Trauma Center accessible to the Meadowbrook and Southern State Parkways, and the only Level I or Level II Trauma Center in all of eastern and central Nassau. In 2001, NUMC delivered about 60% of all the Emergency Room visits in eastern/central Nassau. NUMC's Emergency Room also receives large numbers of mentally ill patients as a Mental Hygiene Law §9.39 receiving Emergency Room.

However, NUMC also performs somewhat more primary care in its Emergency Room than do other hospitals in the area, and this partly explains the large number of Emergency Room visits at NUMC. A greater percentage of the ER patients at North Shore and LIJ are admitted to both of those hospitals than are admitted from NUMC's ER (30% compared to 22% at NUMC). This fact suggests more frequent inappropriate usage of the NUMC ER for primary care than at other high volume facilities in Nassau.

NUMC is the dominant provider of Emergency Room visits to Medicaid and uninsured patients in Nassau County. NUMC provides almost 40% of both Medicaid Emergency Room visits and uninsured Emergency Room visits. Almost 40% of the visits to the NUMC ER are from uninsured patients, compared to 11.5% at North Shore/Manhasset and 12.5% at LIJ.



Ambulatory Care

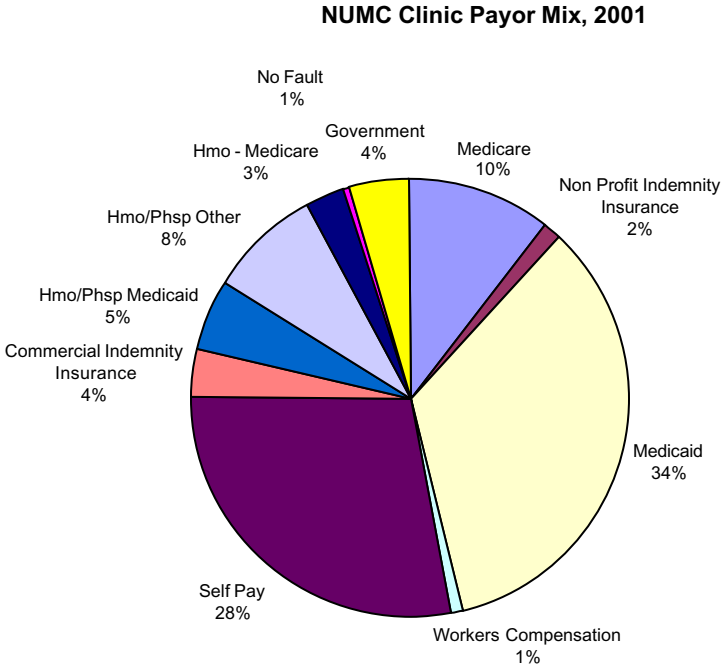
Clinic/Outpatient Department

NUMC's Outpatient Department is the second largest in Nassau County (with the largest, Long Island Jewish, drawing on both Nassau County and Western Queens.) The NUMC hospital-based clinic had almost 250,000 visits in 2001, almost one in four hospital-based clinic visits in Nassau County.

NUMC is one of two major hospital-based outpatient facilities in the Hempstead area, a heavily low-income community. The other, Mercy Medical Center's OPD, sees about 40% less volume than the NUMC OPD. Furthermore, OPD visits at Mercy Medical Center are predominantly for mental health and substance abuse services. More broadly, NUMC dominates hospital-based clinic services in Hempstead and in central and eastern Nassau County.

A significant percentage of NUMC's outpatient care is uncompensated, and much of the remainder is reimbursed by Medicaid at extremely low capped clinic rates. Medicaid and uncompensated/self-pay patients represent over 60% of NUMC clinic volume. The NUMC outpatient clinic is the dominant hospital-based provider of primary care for low-income individuals in the County. Three quarters of uninsured OPD visits in the County are at NUMC, and 28% of the OPD visits at NUMC are from uninsured patients, compared to only 4% at LIJ. (These figures assume that those patients classified as uninsured were actually uninsured, rather than insured but not billed because of problems in the eligibility and billing process.)

34% of the OPD visits at NUMC are from Medicaid fee-for-service patients, while only 5% are from Medicaid managed care patients. At LIJ, 38% of the OPD visits are from Medicaid fee-for-service patients and 28% are from Medicaid managed care patients. In counties, such as Nassau, where only the sickest Medicaid patients are exempt from managed care enrollment, Medicaid fee-for-service patients tend to be the more expensive patients. Moreover, the small percentage of Medicaid managed care visits suggests either that NUMC does not have contracts with the major Medicaid managed care plans or that managed care patients are selecting primary care providers that are not affiliated with NUMC.



Community Health Centers

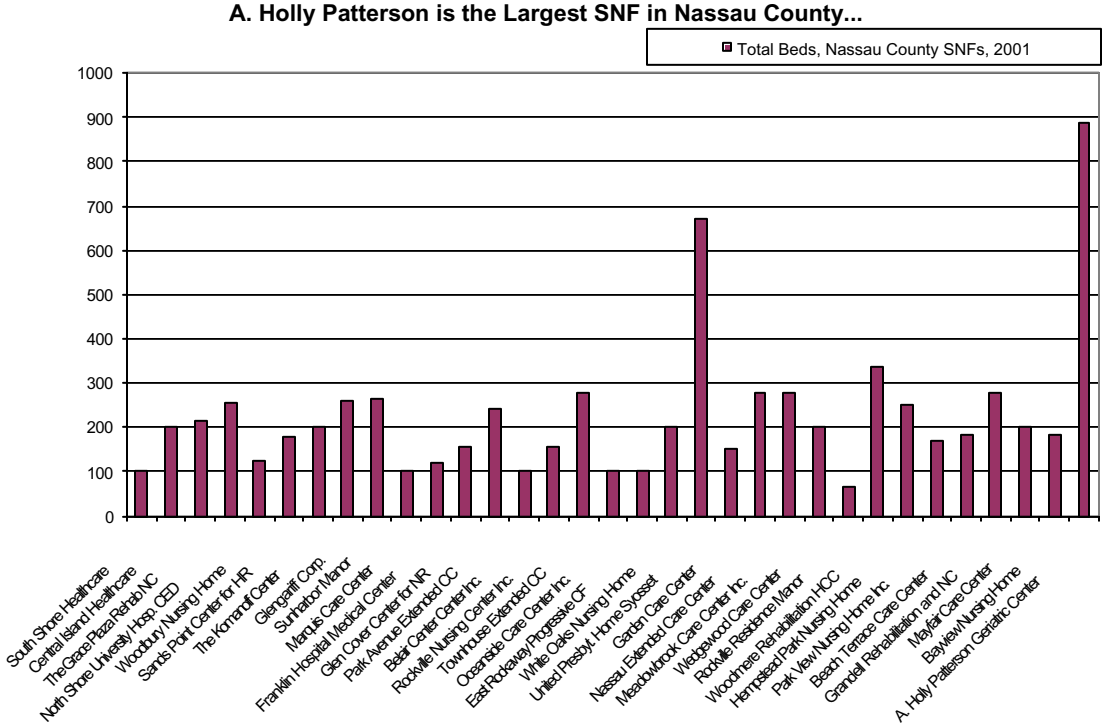
NHCC operates seven community health centers – Hempstead, Freeport, New Cassel, Elmont, Inwood, Long Beach, and a school health clinic in Roosevelt. In 2001, these facilities delivered 57,000 visits. This was down over 30% from the 1999 levels, and far smaller than the number of visits delivered in NUMC's Outpatient Department. Yet, NHCC's Medicaid rate for the DTCs—$132.61 per threshold visit[4]—is one of the highest in the state and the highest of any County-operated Diagnostic and Treatment Center system. It is almost twice the capped reimbursement rate for hospital clinic visits.

Skilled Nursing Facility

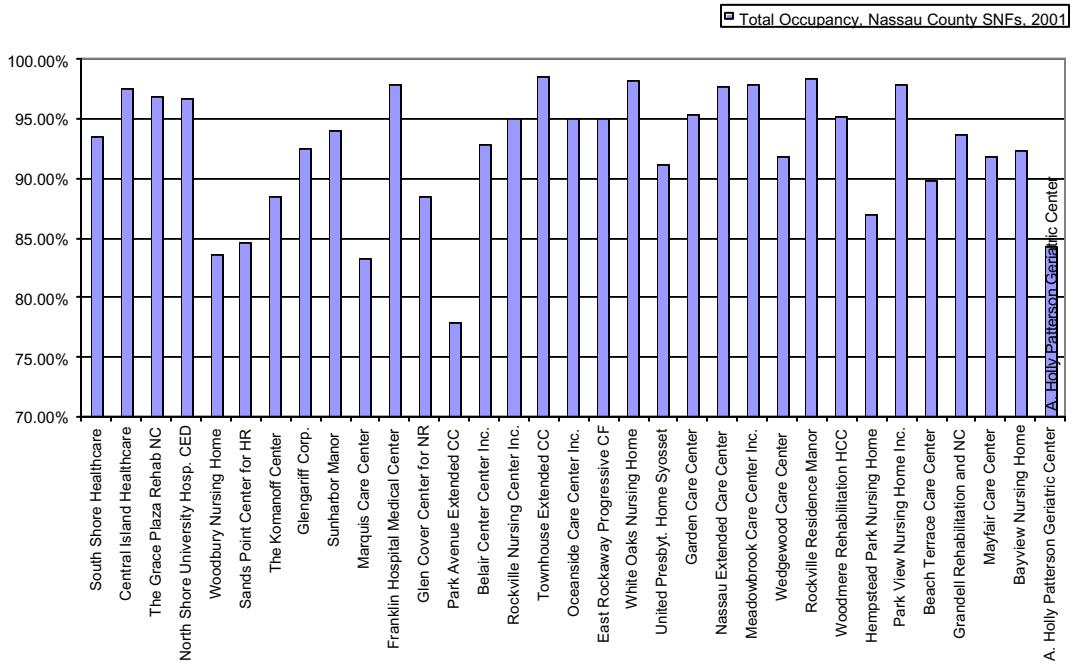
NHCC's nursing home, A. Holly Paterson ("AHP"), is the largest skilled nursing facility ("SNF" or "nursing home") in the County and one of the largest in the United States. Only three SNFs in Nassau County have lower occupancy rates. Medicaid represented 92.5% of A. Holly Paterson's payor mix in 2001, higher than any other Nassau County SNF. AHP provides about 1000 discharges annually to NUMC (NHCC's Hospital), a significant percentage of NUMC admissions and a large share of NUMC's Medicare admissions.

[4] "Threshold visit" refers to the fact that a DTC can only bill once for each day a patient crosses the threshold of the center, even if the patient sees more than one professional during that visit.

A. Holly Patterson is the Largest SNF in Nassau County...



..And Has One of the Lowest Occupancy Rates.



B. Capacity of Other Facilities to Absorb NHCC Volumes

Acute/Hospital

- Based on the results of this Market Analysis and interviews conducted with the three major hospital systems in Nassau County—Catholic Health Services of Long Island, the North Shore-Long Island Jewish Health System, and the Winthrop-South Nassau System, it appears that there is limited capacity in Nassau County to absorb the inpatient and Emergency Room volumes currently provided at NUMC. While the responses from the three systems were consistent with general industry trends of high utilization, as reflected in the Market Analysis, their statements concerning their staffing, financial resources and related matters, were not independently verified.

- The alternative capacity is inadequate for several reasons.

- First, inpatient occupancy rates and Emergency Room utilization rates are generally high in Nassau County, meaning that there are physical constraints on the bed and Emergency Room capacity of area hospitals. As detailed in the attached Market Analysis, other large hospitals in Nassau County have inpatient occupancy rates of 90-95%.

- Second, hospital executives express extreme concern about their ability to expand their staffing, particularly nursing staff, to accommodate additional volume.

- Third, NUMC currently sees an enormous proportion of the uninsured Emergency Room and outpatient clinic volume in the County, about 40% of uninsured ER visits and over 70% of uninsured outpatient clinic visits.[5] Area hospitals may not have the financial capacity to take on the large volume of indigent care currently handled by NUMC and the NHCC clinics.

- Finally, there are significant questions concerning geographic accessibility of other hospitals, particularly in the context of timely transport of patients to the Emergency Room/Trauma Center.

- In most sub-specialties, there is capacity in area hospitals to absorb the relatively low volumes currently seen at NUMC.

Ambulatory Care

- There is very little alternative primary care capacity for uninsured and Medicaid patients in Nassau County. In addition to providing the vast majority of uninsured clinic visits, NUMC delivers almost 30% of all Medicaid primary care visits in Nassau County in its Outpatient Department, and in the NHCC Diagnostic and Treatment Centers, which also see a significant percentage of uninsured and Medicaid patients.

[5] These figures assume that those patients classified as uninsured were actually uninsured, rather than insured but not billed because of problems in the eligibility and billing process.

Nursing Home

- The Nassau County market for nursing home services is soft.
- However, given the size of AHP, the capacity of area nursing homes to absorb its patients is questionable.
- AHP's patient mix is difficult and often not attractive to other homes.

C. Findings From The Demographic and Market Analysis Regarding NHCC's Role

The Demographic and Market Analysis supports the conclusion that the role of NHCC and its three enterprises in the healthcare system in Nassau County is as a provider of basic inpatient, emergency and outpatient care to Nassau County residents, particularly those covered by Medicaid or without insurance coverage. NHCC and its enterprises, although staffed as if they were major components of an academic medical center providing a full range of tertiary care, in fact play the role of a community hospital that serves as a "safety net" provider to the County's medically indigent.

Specifically, NHCC's hospital, NUMC, provides significant volumes of inpatient and outpatient care in Pediatrics, Psychiatry, Substance Abuse, HIV, Obstetrics and Internal Medicine. NUMC's Emergency Room volumes follow a similar pattern, including a significant role as a "receiving hospital" under Section 9.39 of the New York Mental Hygiene Law, for individuals requiring psychiatric hospitalization. Much of the volume in NUMC's Emergency Room is for primary care, rather than true emergencies. NUMC's primary care clinics provide similar services, making NUMC, in effect, the family doctor to Nassau County's Medicaid and uninsured population.

This primary care focus and low patient acuity is reflected in NUMC's case mix index of 1.2, as compared to the much higher case mix index numbers associated with academic medical centers and true tertiary care facilities. While NUMC has numerous specialty clinics, as do the DTCs, and while NUMC maintains Level I Trauma center designation and operates specialty units (including a Burn Center and Hyperbaric Chamber), the volumes of patients treated in those specialty settings is relatively small, and are not within the core mission of NHCC's hospital and ambulatory care network enterprises. A similar range of primary care services predominates in NHCC's seven community health centers or DTCs.

NHCC's nursing home, the A. Holly Patterson Extended Care Facility, while one of the largest in the United States, similarly serves a low acuity patient population, including hard-to-place individuals who might be able to be placed in other settings. Despite operating several specialty units, AHP's case mix is at or slightly above 1.0, which reflects low acuity and, in some cases, raises the question whether nursing home placement is appropriate. In contrast to the other enterprises, it is not clear whether there is sufficient capacity and willingness in the nursing home community to accept the AHP patients, if transfer were attempted. This issue is discussed in more detail in Chapter VI of this Report.

IV. Strategic Options

A. Introduction

This section addresses the following question posed earlier, through the definition and consideration of six Strategic Options. The question posed was:

> Should NHCC as a whole, or by enterprise (Acute, SNF, Ambulatory Care) continue to operate healthcare facilities?

Each of the six Strategic Options has been analyzed with respect to the three major "enterprises" operated by NHCC. Each enterprise has distinct operational, financial and administrative requirements and characteristics that require separate analysis and treatment. The three enterprises are:

> Acute/Hospital, which includes NUMC's inpatient hospital care, Emergency Room/Trauma, and the eighty-one clinics operated by the Hospital Outpatient Department ("OPD").
>
> Nursing Home, which includes the A. Holly Patterson Extended Care Facility, the Certified Home Health Agency and other long-term care programs (if any).
>
> Ambulatory Care, which includes the Diagnostic and Treatment Centers, school health clinic and other ambulatory programs operated by NHCC. This category is closely related to the Hospital OPD, because the DTCs and OPDs provide similar care.

B. Principles Governing The Formulation And Selection Of Strategic Options

The following basic principles need to be acknowledged in order to place the Strategic Options and Key Findings and Recommendations in a realistic context:

- Nassau County has no constitutional or statutory mandate to directly provide healthcare services, except for a small number of specific obligations that would apply to any county, including: providing for healthcare services to inmates in the County correctional facility, and providing certain public health services, in the areas of infection control, disease prevention and immunization. To the extent the County historically has provided hospital, nursing home and ambulatory care services directly, those direct services were transferred to NHCC, thereby eliminating any direct County obligation to provide them. The only remaining County obligations derive from the County's guarantee of the 1999 $256 million bond issue, and from any adequately defined and enforceable financial obligations under the Acquisition and Services Agreements.

- NHCC is a State-created public benefit corporation, under the New York State Public Authorities Law. The County Executive and County Legislature therefore have limited control and authority to effectuate changes at NHCC, although the functions being performed by NHCC are entirely local in nature, and although Nassau County is at financial risk for NHCC's failed financial performance through its guarantee of NHCC's 1999 Bond Issue.

- NHCC's principal purpose is to provide healthcare services to the residents of Nassau County, particularly those who are medically indigent. NHCC's role has been examined in the context of the healthcare needs of the community, specifically, the medically indigent, and the capacities of the other Nassau County healthcare providers to meet those needs.

- The financial legacy related to the $256 million borrowing, coupled with other related historic County debt associated with the NHCC facilities, must be dealt with in a manner that does not compromise Nassau County's progress toward financial stability.

- All stakeholders must reach a consensus as to the future plan for NHCC if Nassau County is not to be adversely impacted financially, and if NHCC and its three operating divisions are to fulfill their mission and become financially viable. The major stakeholders include: the County Executive, the County Administration and County Legislature; NHCC's Board and Administration; the New York State Executive and Legislative branches, including the Governor, the Assembly and Senate leadership, and the Nassau delegation; State regulatory agencies (Department of Health, Office of Mental Health, Corrections); County regulatory agencies (Departments of Health, Mental Health and Social Services; Sheriff); The Nassau Interim Finance Authority ("NIFA"); Community Leaders; and Labor Representatives.

C. Strategic Options Defined

The six Strategic Options analyzed are:

Option I – Maintain Current Structure and Resolve Disputes. The current structure of the NHCC would be maintained, as would the existing agreements between Nassau County and the NHCC. The parties would attempt to resolve existing and future contractual disputes.

Option II – Closure. Seek to close all or segments of health care services provided directly by Nassau County and/or the NHCC. This Option could be implemented for all or some of the NHCC enterprises: Acute/Hospital; Nursing Home; and Ambulatory Care.

Option III – Sale or Transfer. Nassau County and NHCC agree to sell or otherwise transfer all operating certificates, licenses and other assets to other providers, to permit continued operations under new provider ownership. The other providers could consist of one entity for all NHCC enterprises or a separate entity for each NHCC enterprise. Such entities could be existing established healthcare operators, or new not-for-profit or for-profit corporations.

Option IV – Management and Professional Services Agreement. Nassau County and NHCC enter into an agreement with another healthcare provider or with a hospital, nursing home or ambulatory care management company, to manage one or more of the licensed facilities and/or to provide professional staffing for NHCC programs.

Option V – Amend NHCC Enabling Statute and Total Restructuring Of NHCC. Nassau County and NHCC agree to restructuring of the relationship between NHCC and the

County, and of the scope of activities of the NHCC enterprises, and necessary amendments to NHCC's enabling statute would be adopted. Each enterprise would become a subsidiary corporation of NHCC, with its own Board of Directors. This would enhance Board focus on, and accountability for, an appropriate scope of operations, as to which each Board would be expected to become educated. Each entity would have its own separate administrative structure, separate medical staff structure, and would manage its own operations, finances, personnel, and facilities. Where appropriate, there could be shared services arrangements among the subsidiaries, based on objective financial benefits. Consistent with the final findings and recommendations, each entity would modify the scope of its programs to reflect its appropriate clinical, educational and research purposes in the context of its role as a provider in the healthcare delivery system in Nassau County, including possibly management, administrative services and/or professional affiliation agreements. Nassau County's relationship with each subsidiary would be negotiated separately.

Option VI – Amend Enabling Statute and Agreements. The contractual arrangement between the County and NHCC would be re-negotiated, to define and quantify the parties' respective obligations, including the debt service, imposition of performance standards, third party payor limitations on payments for care provided by NHCC, and better definition of the nature and scope of services provided by NHCC and payments made by the County. The NHCC enabling legislation would be amended in order to permit the implementation of agreed upon measures to improve operational and cost efficiencies at NHCC (e.g., modification of civil service requirements).

D. Recommended Strategic Option

In order to select among the Strategic Options for NHCC as a whole, and for each NHCC enterprise, the starting point is the role each enterprise plays in delivering services to Nassau County residents, the financial implications of that role, and whether that role could be assumed by others.

It is clear from the Market Analysis that the NHCC enterprises fulfill several important roles, for which realistic alternatives do not exist, and therefore, some or all of the NHCC enterprises need to continue to exist. Yet, on their present course, NHCC and its enterprises are deeply troubled. They lack the governing board oversight, management depth, accountability and financial discipline necessary to avoid collapse when cash runs out in the next 12 to 18 months.

In view of the continuing need for many of NHCC's programs, closure (Strategic Option II) is not recommended. The role NUMC plays is to provide primary and secondary services in Pediatrics, Psychiatry, Substance Abuse, HIV, Obstetrics and Internal Medicine, Emergency Room and Trauma services, and Ambulatory Care. In each of these areas, as demonstrated by the Market Analysis, NUMC is the major provider of care to Nassau County's residents who are covered by Medicaid or who lack health coverage altogether. If NUMC were to close, care to those populations would be disrupted. Some patients would delay care and others would forgo care altogether, unable to access other providers in Nassau County. The Market Analysis, and interviews with the major healthcare systems in Nassau County, confirm that, in addition to lack of transportation and other accessibility issues, the other providers in Nassau County do not have the capacity to absorb the volumes of Emergency Room and primary and secondary care provided by NUMC on an inpatient and outpatient basis.

In addition, NUMC is a major employer in an economically vulnerable area, and it annually draws in approximately $265 million in Federal Medicare and Medicaid funds. While the County pays approximately 25% of Medicaid benefits paid on behalf of County residents, the remaining 75% of Medicaid and 100% of Medicare, as well as other third party payor and revenue streams of approximately $70 million, represent a major influx of funds into the County in general, and into the community surrounding NUMC in particular. NUMC and its more than 3000 employees, in turn, are major purchasers of goods and services within those communities.

While the County currently serves as the guarantor of the $256 million Bond Issue, the primary obligation to pay the debt service is imposed on NHCC. Closure would make the County the primary obligor with respect to that borrowing. Closure also would accelerate a variety of obligations associated with the closing of a business, including approximately $70 million in accrued employee-related liabilities, primarily for accrued vacation and sick leave. In addition, Workers' Compensation and other significant costs associated with closure would be incurred.

Finally, NUMC has the potential for taking the necessary steps to maximize revenues, reducing costs to industry standards and achieving a level of financial efficiency. Upon implementation of these steps, it would be possible to reduce debt, while still having the County meet select, well-defined obligations. Achieving these levels of cost reduction and efficiency would establish the basis for confirming that the County payments were being applied to the identified purposes, rather than to cover excessive costs.

Continuation of the status quo (Strategic Option I) is not a viable option, given the projected budget shortfalls and cash crisis, and the documented need to focus NHCC's programs on the services most needed by its patients. Similarly Strategic Option VI (Modify Enabling Statute and Agreements) does not provide for the programmatic and structural changes necessary to address NHCC's financial problems.

Sale or transfer of NHCC or its enterprises (Strategic Option III) or seeking a Management and Professional Services Agreement (Strategic Option IV) are not viable because potential purchasers or managers would require resolution of many of the major issues and problems prior to assuming responsibility for NHCC or its enterprises.

Strategic Option V (Modify NHCC Enabling Statute and Total Restructuring of NHCC) is recommended because it provides an approach and framework for restructuring NHCC and its enterprises to provide the appropriate scope of programs to meet the health care needs of the community it serves, while at the same time working toward financial stability, reduced reliance on County subsidiaries, and appropriate governance, management and accountability.

E. Guiding Principles In Implementing The Recommended Strategic Option

Having studied NHCC and its enterprises from the County's point of view, and having concluded that some of NHCC's programs and services should continue, the County must be assured that they will be continued in a manner that meets the following healthcare policy and financial requirements:

- The determination whether to close an enterprise, or whether to continue a particular program, and how to structure programs, should start with a determination of the role it plays in the Nassau County health care marketplace.
- There must be a documented need for the specific services provided by NHCC which otherwise could not be met by other providers in the foreseeable future (i.e., 5 to 10 years).
- To the extent that NHCC's operating divisions are to continue, they must urgently take the steps to become financially viable.
- Any operations that are to continue must be completely and thoroughly restructured, as described in this Report.
- Restructurings should be implemented based on well-formulated transition plans that recognize that patient care must not be disrupted, and that individual administrators, physicians, residents, and employees should have the opportunity to plan for and re-direct their professional lives.
- NHCC's governing board should be restructured to provide for accountability and responsiveness to local elected and appointed officials, as more fully described below.
- To the extent that recommendations require legislative changes, pending the adoption of such changes, many of the recommendations can be adopted consensually, and interim steps taken, pending approval of legislative changes.

V. Specific Key Findings And Recommendations Regarding NUMC

A. Introduction

Having concluded that NUMC should not be closed, this section sets forth specific findings and recommendations with respect to NUMC. Consistent with Strategic Option V (Modify NHCC Enabling Statute and Total Restructuring of NHCC), each program should be reviewed, together with consideration of the utility of shared services arrangements, management contracts and/or professional affiliations.

Although previously discussed, it warrants repeating: NUMC is basically a community hospital providing primary and secondary levels of care to the community it serves. A detailed examination of the kinds and volumes of clinical services it has historically and currently provides confirms this characterization. It also provides the basis upon which NUMC's strategic business and financial plan should be made, and is reflected in the recommendations.

NHCC's attempts and various forays into tertiary care initiatives have been and continue to be ill-advised and wasteful. It has neither the standing in the healthcare marketplace, the volumes and complexity of cases required, nor the personnel and capital resources required to establish and compete with the other tertiary care providers in Nassau County. Compounding the problem, NUMC has over many years adopted the cost profile of a major tertiary academic medical center. Unfortunately it has not had, and currently does not have the necessary patient volume, levels of acuity (case mix) and payor mix to support such a designation.

NUMC's current licensed inpatient capacity is 631 beds, in the following categories:

Medical Surgical	301
Intensive Care	16
Coronary Care	12
AIDS	20
Total Med/Surg.	349
Pediatric	46
Maternity	36
Phys. Med. and Rehab.	30
Psychiatric	90
Burns Care	10
Pediatric ICU	6
Alcohol Detox	10
Prisoner	16
Neonatal	38
Total:	631

In the first eight months of 2003, NUMC's beds are approximately 60% occupied, an improvement, but still below the occupancy levels of other hospitals in Nassau County.

NUMC provides significant volumes of inpatient and outpatient care in Pediatrics, Psychiatry, Substance Abuse, HIV, Obstetrics and Internal Medicine.

NUMC's Emergency Room volumes follow a similar pattern. Much of the volume (approximately 80%) in NUMC's Emergency Room is for primary care, rather than true emergencies. In addition, NUMC's Emergency Room plays a significant role as a "receiving hospital" under Section 9.39 of the New York Mental Hygiene Law, for individuals requiring psychiatric hospitalization.

NUMC's primary care focus and low patient acuity is reflected in NUMC's case mix index of 1.2, as compared to the much higher case mix index numbers (1.7 to 2.0 or more) associated with academic medical centers and true tertiary care facilities.

NUMC's clinics also provide primary care services, making NUMC, in effect, the family doctor to Nassau County's Medicaid and uninsured population. A similar range of primary care services predominates in NHCC's seven community health centers or DTCs. While NUMC has numerous specialty clinics, and while NUMC maintains Level I Trauma Center designation and operates specialty units (Burn Center, Hyperbaric Chamber), the volumes of patients treated in those specialty settings is relatively small, and are not within the core mission of NHCC's hospital and ambulatory care network enterprises.

The health services provided by NUMC to inmates in the county prison have been criticized for inadequate administration, management, clinical services (including both quality and timeliness of care), over utilization, and excessive costs. The separate confidential study of Prison Health recommends that a Request for Proposals be issued to address the substantive concerns and to revise the economic relationship with the provider of prison health services.

B. Key Factors Which Contribute to the Poor Financial Performance of NUMC

Our review of NUMC revealed the following key factors that have contributed to its poor financial performance:

- Utilization. Total Discharges, Emergency Room Visits, Outpatient Visits and Ambulatory Surgeries utilization have remained relatively stable, with some recent improvement in Adult and Pediatric discharges and a downward trend in Psychiatric discharges, although the length of stay in Psychiatry increased from 12.1 days to 17.9 days.

- Case Mix Index. The Case Mix Index ("CMI") is a critical component of the health care reimbursement system, since payments increase to reflect higher levels of patient acuity. NUMC's case mix is 1.23, which is extremely low. Academic medical centers typically have a CMI range of 1.70 to 2.00. To put CMI in perspective, an increase of .01 in CMI is estimated to be worth approximately $1.2 million in annual reimbursement.

- NUMC Cost Structure. NUMC has the cost structure of a large academic medical center, but does not have the patient base in terms of volumes or case mix, to support its cost structure.

- NUMC Productivity and Staffing. NUMC continues to be significantly overstaffed and does not achieve industry standard productivity. The two standards for measuring staffing needs and productivity are the number of Full

Time Equivalents ("FTEs") per adjusted occupied bed,[6] and payroll as a percent of revenues. NUMC's current staffing, stated in terms of FTEs per occupied bed, was 5.16, after the recent staff reduction. Academic Medical Centers are at levels ranging between 4.5 to 5.0 FTEs. Stated in terms of percent of Patient Revenue, the 2003 median for nonprofit hospital and health care systems is 52%, with a below investment grade hospital at 54.7%. NUMC's payroll as a percent of revenues is over 71%.

- NUMC Physician Staffing and Productivity. Physician Compensation makes up 19% of NUMC's salary costs. Given the analysis of patient volumes and acuity (CMI) discussed above, by any empirical analysis, the physician staffing, productivity and compensation levels at NUMC need to be further reduced, and/or the physician staffing and compensation arrangements need to be substantially modified.

- Revenue Cycle. Previous studies have identified the need for improvement in NUMC's revenue cycle. Cap Gemini projected approximately $14.3 million could be generated upon implementation of its suggestions. In addition, improvement in the Medicaid application process, particularly in the outpatient setting, including capture of information and follow up, could result in a higher level of coverage for patients, and corresponding improved reimbursement.

- NUMC Indigent Care and Excess Costs. Among the most difficult factors to determine is the true cost of bad debt and charity care. Rather than measuring free and reduced price care, the calculation of indigent care for reimbursement purposes does not correspond to the purposes of the County's "mission payment" to NHCC. NHCC's reports for reimbursement purposes reflect various artifacts, including poor credit and collection processes, allocation of excessive costs, and inclusion in the calculation of shortfalls in third party reimbursement. Because the reasonable cost of free and charity care is the key ingredient in determining the level of County subsidy needed to support the "mission" of NUMC as the provider of last resort to medically indigent patients, the current flawed basis for defining this "mission" subsidy must be re-defined to track the reasonable cost of providing care to the medically indigent, after taking into account funding from other sources.

C. Need to Contractually Affiliate with a Strong Healthcare Network and Regionalize Clinical Services

NUMC will have great difficulty becoming financially viable as a stand alone general acute care community hospital. It is facing reduced reimbursement from third party payors, increasing labor costs, including underfunded pension obligations, limited or non-existent negotiation leverage with managed care companies (HMOs), and high cost investment in information and medical technology.

Given the factors enumerated above and the need to effectuate the recommendation in a timely fashion, as soon as practicable NUMC should undertake to identify, negotiate and execute

[6] Adjusted to reflect outpatient, Emergency Room and Ambulatory Surgery staffing requirements.

a carefully structured affiliation contract with one or more of the healthcare systems in Nassau County.

The scope of these contractual arrangements may include:

(i) Regionalization of select clinical services.

(ii) Unifying the management and administration of clinical departments under a common clinical chair.

(iii) Provision of attending physician staff for all or some of the clinical departments.

(iv) Integration of all or some of the graduate medical education/residency training programs.

(v) Shared services, particularly in select areas such as information technology and joint purchasing.

(vi) Turn-key management of select administrative and clinical departments.

The ultimate objective is to make NHCC and its three enterprises an integral part of a larger healthcare service network through a public/private partnership. This integration not only would contribute significantly to improving the clinical and financial performance of NHCC, but also would go a long way toward breaking down historic barriers to access to the best health care available in Nassau County, for all patients, including the indigent.

D. NUMC's Scope of Programs, Medical Staffing, Physician Arrangements and Teaching Programs; Key Findings and Recommendations

1. Introduction

Once the hospital's core services and role in the Nassau County health care system are defined, the Medical Staffing, Physician Arrangements and Teaching Programs related to both core and non-core services can be reviewed, adapted and restructured, as appropriate, to carry out that core mission in a cost-effective manner, based on industry norms.

Development of these key findings and recommendations begins with, and is driven by, the following source data concerning NUMC's role in the Nassau County health care system:

- SPARCS[7] and FACETS[8] data on discharges and market share. These data are compiled and reviewed in great detail in the Market Analysis (Exhibit E) and in the summary in Chapter III. It should be noted that SPARCS and FACETS data are drawn from information submitted by hospitals in claims processing, and generally

[7] SPARCS stands for the Statewide Planning and Research Cooperative System. Each year approximately 2.5 million hospitalizations in NYS are reported to SPARCS. The database contains over 120 data elements describing the patient, hospital, health care provider and the hospitalization stay.

[8] FACETS is a software package that provides patient-level analyses of hospital- and market-specific inpatient and ambulatory surgery utilization as reported by SPARCS.

differ slightly from Institutional Cost Report Data. However, SPARCS data are reported consistently across institutions, allowing for accurate comparisons and rankings of hospitals.

- Statistical information maintained by the hospital, and reported to third party payors in the hospital's Institutional Cost Report, which is certified by the hospital's auditors.

2. Medical Program Configuration

Using this information, NUMC's services are classified into "core" and "non-core" services. Core services are those that are essential to NUMC's mission, based on achievement of a level of activity (by percentage market share and/or number of discharges or visits in ambulatory care services) that reflects reliance by the community on NUMC for the particular service.

Non-core services are those with marginal market percentages and very low numbers of discharges or visits. Once classified as non-core, each service must then be analyzed to determine whether it should continue to be provided at NUMC, or whether it should be regionalized at another provider through transfer and affiliation arrangements. For those non-core services that will be continued at NUMC, a similar analysis should be applied to determine the appropriate medical staff complement. Physician arrangements, including compensation, should be analyzed in detail, and adjusted to conform to conservative national norms, either through continued employment of physicians or through professional affiliations.

The following table provides critical information regarding the number of patients treated and percentage market share in each of the services tracked in the SPARCS database, over a four year period. The SPARCS data confirm that NUMC is fulfilling the role of a community hospital providing primary and secondary care, in Pediatrics, Psychiatry, Substance Abuse, HIV, Obstetrics and Internal Medicine. The low volumes and market shares in tertiary services are consistent with this conclusion.

TABLE 7: NASSAU COUNTY RESIDENTS - TOTAL INPATIENT DISCHARGES BY CLINICAL SUB-SPECIALTY (Source: SPARCS) [9]											
	2000			2001			2002				
Clinical Sub-Specialty	**Total Disch.-- All Nassau Cty**	**NUMC Mkt Share**	**NUMC Disch**	**Total Disch.-- All Nassau Cty**	**NUMC Mkt Share**	**NUMC Disch**	**Total Disch.-- All Nassau Cty**	**NUMC Mkt Share**	**NUMC Disch**	**Change in NUMC Market Share 1999-2002**	**Change in NUMC Disch, 1999-2002**
Cardiology	19,980	6.3%	1,254	20,354	7.6%	1,545	20,263	8.4%	1,697	1.3%	301
Obstetrics	19,107	14.4%	2,754	18,505	14.6%	2,702	17,929	13.5%	2,418	2.0%	284
Newborn	15,549	12.9%	1,999	14,881	12.7%	1,886	14,273	11.1%	1,581	0.7%	-26
Pulmonary Medicine	11,726	8.0%	933	11,021	7.4%	821	11,422	8.5%	972	-0.6%	-83
Gastroenterology	11,005	5.0%	555	11,579	4.4%	511	11,965	5.8%	698	-0.1%	76
General Surgery	10,831	6.1%	660	10,642	5.1%	545	10,334	6.0%	616	-0.1%	-34
Orthopedics	9,316	5.8%	538	9,351	5.1%	475	9,528	7.3%	694	2.2%	240
Pediatrics	8,838	24.8%	2,193	9,085	23.0%	2,093	8,217	23.8%	1,952	1.8%	94
Neurology	6,824	9.6%	652	7,263	8.7%	634	7,252	11.2%	815	2.3%	222
Cardiology-Invasive	6,154	2.0%	121	7,040	2.3%	161	6,984	2.7%	186	0.0%	30
Psychiatry	5,931	32.2%	1,910	5,818	27.1%	1,576	5,593	23.5%	1,312	-7.0%	-485
Urology	4,248	4.0%	170	4,570	4.2%	193	4,027	5.3%	214	1.8%	71
Oncology	3,932	2.8%	109	3,753	2.4%	90	3,393	4.0%	136	1.6%	42
Endocrinology	3,618	9.9%	356	3,735	7.5%	281	3,891	10.1%	394	-1.0%	-12
Substance Abuse	3,593	23.6%	848	3,676	26.2%	962	3,650	22.7%	828	-3.8%	-145
Gynecology	3,495	6.8%	236	3,481	6.9%	239	3,548	6.4%	227	-1.1%	-24
Infectious Diseases	2,917	5.4%	157	2,952	4.6%	137	2,975	6.4%	189	-2.2%	-76
Nephrology	2,949	9.7%	285	2,921	6.8%	198	2,911	8.7%	253	-1.4%	-19
Rehabilitation	2,880	18.0%	517	2,887	17.9%	518	2,538	9.4%	239	-4.8%	-159
Cardiac Surgery	2,887	0.0%	0	2,678	0.0%	0	2,629	0.0%	1	0.0%	1
Vascular Surgery	2,290	4.1%	95	2,125	3.0%	64	2,172	3.0%	65	-1.3%	-37
Neonatology	1,607	15.5%	249	1,646	12.8%	210	1,494	10.6%	158	-2.0%	-39
Neurosurgery	1,544	3.9%	60	1,608	3.2%	52	1,571	3.7%	58	0.2%	7
Otolaryngology	1,362	10.1%	137	1,400	10.4%	145	1,346	12.3%	165	-2.8%	-42
Hematology	1,282	12.1%	156	1,305	7.7%	101	1,269	9.5%	120	-2.6%	-18
Thoracic Surgery	1,268	7.5%	95	1,264	4.2%	53	1,239	5.6%	70	0.4%	11
Adverse Effects	855	17.2%	147	863	17.3%	149	924	18.7%	173	-1.8%	-16
Plastic Surgery	655	9.5%	62	579	7.9%	46	558	8.8%	49	2.2%	11
HIV Infection	482	43.7%	211	521	42.0%	219	516	40.7%	210	-2.1%	-20
Dermatology	507	11.9%	60	499	9.8%	49	538	10.4%	56	2.0%	17
Rheumatology	225	7.5%	17	197	7.1%	14	224	14.7%	33	3.4%	6
Signs & Symptoms	157	6.3%	10	173	8.1%	14	230	16.5%	38	10.2%	28
Ophthalmology	166	8.8%	15	191	12.0%	23	168	16.1%	27	0.0%	-2
Oral Surgery	101	15.1%	15	86	15.1%	13	93	16.1%	15	4.4%	1
Burns	89	57.9%	52	80	55.0%	44	86	62.8%	54	-2.5%	-8
Other	5,413	7.5%	404	5,489	6.5%	357	5,484	7.7%	425	1.0%	65
Total	173,783	10.4%	18,031	174,218	9.8%	17,120	171,234	10.0%	17,138		

[9] See the Market Study, Exhibit E, which includes 1999 data.

Based on the foregoing empirical information, the major services have been classified as "core" or "non-core-to be regionalized." Core services include Internal Medicine,[10] Obstetrics, Newborn and Neonatology, Pediatrics, Psychiatry, Substance Abuse, General Surgery, HIV, Rehabilitation and Prison Health.

Non-core services, to be considered for regionalization and/or consulting arrangements, include Neurosurgery, Otolaryngology, Ophthalmology, Oral Surgery, Orthopedics, Plastic Surgery, Thoracic Surgery, Vascular Surgery, Cardiac Surgery, Cardiology – Invasive, and Burns.[11] In addition, as part of the business planning process, consideration should be given whether some of the sub-specialties included within the core services should be regionalized with other providers.

These conclusions are subject to in-depth discussion with each NUMC Chairman as part of the process of developing a business and financial plan for each department. Those plans should reflect: the actual levels of care provided in each service; whether selected services should be regionalized as a whole or by sub-discipline; staffing requirements attendant to each clinical service; and impacts on teaching programs, physician arrangements, including physician compensation, and potential regionalization. The extent to which a particular program is necessary to maintain Emergency Room/Trauma Center coverage, or to meet Graduate Medical Education Program requirements, are relevant, but not dispositive, since such coverage or requirements can be met through affiliation and regionalization arrangements.

Finally, in the business planning process, the reimbursement stream associated with the physician component of each service should be analyzed in detail, recognizing that reimbursement streams for primary care services may be insufficient to cover the entire physician cost of services provided at NUMC. In those services, properly sized subsidies may need to continue, or other sources of revenue explored.

3. Physician Staffing

Based on the Physician Staffing Analysis (Exhibit J), NUMC's physician complement remains overstaffed, even after reductions that have taken place to date. Moreover, concerns relative to NUMC's physician productivity and compensation should be addressed in the departmental business planning process, using conservative industry standards for productivity and compensation, i.e., 75% of the AAMC[12] Northeast standards. The following chart provides a summary, by clinical area, of the current levels of staffing, and modifications based on those standards, including the revised costs that would result from use of the AAMC Northeast standards.

Most notably, the Physician Staffing Analysis shows that the Department of Medicine has 28.58 FTE physicians, while it needs only 15.06 FTEs, in addition to the 106 residents in the various Medicine-related residency programs, to provide its clinical services. Similarly, Physical Medicine and Rehabilitation has 6.53 FTE physicians, while the physician staffing analytical model determined a need for 1.79, in addition to the 11.83 residents in that Department. Finally,

[10] Internal Medicine includes several sub-specialties whose regionalization should be considered: Cardiology, Dermatology, Endocrinology, Gastroenterology, Hematology, Infectious Diseases, Nephrology, Oncology, Pulmonary and Rheumatology.

[11] Due to the historic importance of the burn unit, further analysis and consideration should be given to potential restructuring, regionalization, and/or fund raising for this important service.

[12] "AAMC" is the American Association of Medical Colleges.

the analysis of Ancillary Departments provided in the chart is limited to physician compensation, since a lack of data and opportunity for in-depth study prevented analysis of staffing needs in those Departments.

Current vs Volume-Driven
NUMC Attending Staffing

Department	Current Residents	Current Attendings	Current Salaries	Model Calculated Needed Attendings	@ AAMC (median) Salaries	Variance FTEs	Salaries
Admitting Departments							
Dentistry/Oral Surgery	10.01	2.00	$360,840	1.68	$194,526	0.32	$166,314
Emergency Medicine	-	27.61	$3,752,763	24.45	$4,010,336	3.16	($257,573)
Medicine	102.66	28.58	$3,991,125	15.06	$1,852,091	13.52	$2,139,034
Neurology	3.42	4.68	$736,763	2.74	$279,838	1.94	$456,925
OB/GYN	12.94	10.55	$1,937,693	11.45	$1,865,603	(0.90)	$72,090
Orthopedics	8.00	4.13	$888,162	4.76	$1,037,589	(0.63)	($149,427)
Pediatrics	31.50	12.62	$1,765,306	15.21	$1,718,866	(2.59)	$46,440
P M & R	11.83	6.53	$966,324	1.79	$223,362	4.74	$742,962
Psychiatry/Alcohol Detox	24.76	10.72	$1,591,271	10.47	$1,246,374	0.25	$344,897
Surgery	41.89	13.32	$2,493,598	12.64	$2,388,538	0.68	$105,060
Subtotal	***247.01***	***120.74***	***$18,483,845***	***100.25***	***$14,817,124***	***20.49***	***$3,666,721***
Ancillary/Core Departments *(assumes current staffing unless noted otherwise)*							
Ambulatory Care		3.02	$483,272	3.02	$371,460	-	$111,812
Anesthesiology*	3.58	13.11	$2,594,626	15.57	$2,942,064	(2.46)	($347,438)
Pathology	9.16	5.08	$689,969	5.08	$619,760	-	$70,209
Radiology	16.50	12.98	$2,429,902	12.98	$2,453,220	-	($23,318)
Subtotal	***29.24***	***34.19***	***$6,197,769***	***36.65***	***$6,386,504***	***(2.46)***	***($188,735)***
GRAND TOTAL	***276.25***	***154.93***	***$24,681,614***	***136.89***	***$21,203,628***	***18.04***	***$3,477,986***

** Assumes 7 rooms Tour 2, 2-3 rooms Tour 3, and 1 room Tour 1 on weekdays; and and on weekends, 2 rooms during Tours 2 and 3; 1 room during Tour 1.*

4. Teaching Programs

With respect to Graduate Medical Education, the extent to which each program contributes to NUMC's clinical mission must be evaluated to determine whether the teaching program should be eliminated, and, if continued, with what complement of residents and faculty. Since NHCC's primary responsibility and principal purpose is the provision of clinical services, any educational and research programs are incidental to the clinical mission of NHCC, and must be appropriately sized, based on the needs of the clinical programs at NUMC, A. Holly Patterson and the Diagnostic and Treatment Centers. These issues should be reviewed with regard to issues of clinical quality and cost, including whether integrating residency programs with other providers will improve and reduce the cost of faculty supervision, and improve the quality of residents that can be recruited to the programs. Finally, addition or restructuring of residency programs in core services should be considered. For example, NUMC should consider whether to add residency programs in Family Practice and Emergency Medicine, which would be more consistent with NUMC's core mission.

Based on low volumes and low acuity, NUMC's teaching programs are likely to face difficulties continuing to meet accreditation requirements over the long term, and therefore, the possibility of eliminating teaching programs must be considered. As noted above, any such major changes in programs should be implemented and phased carefully to avoid disruption of patient care, and of the training and professional lives of the residents and faculty.

With regard to teaching programs, NUMC also should consider integrating some or all teaching programs pursuant to an affiliation agreement. While it is frequently stated within NHCC that the teaching programs pay for themselves, and while there is in fact substantial reimbursement for teaching costs, only 70 FTEs of NUMC's attending physicians are classified as being involved in teaching for reimbursement purposes. See Financial Analysis, Exhibit I. Indeed, Medicare has disallowed $4 million of faculty salaries as excessive. Thus, it appears to be possible to reduce the physician staffing numbers, and to reduce salaries, without adversely affecting graduate medical education reimbursement.

VI. Key Findings and Recommendations Regarding The Nursing Home/AHP

The Key Findings and Recommendations concerning AHP have been developed with the assistance of Paul Rosenfeld and his staff, who conducted an in-depth review of AHP and its operations, including review of a 5% sample of resident records. Mr. Rosenfeld's report (prepared with the assistance of Loeb & Troper) is attached as Exhibit A.

A. Key Findings

- AHP's current licensed capacity is 889 beds, of which approximately 650 are currently occupied.
- AHP's Case Mix Index is slightly more than 1.0, reflecting the low acuity level of AHP's patients, and raising the question whether 30% or more of AHP's patients could be placed in other settings (e.g., supportive housing), to the extent such facilities are available.
- Apart from its current occupancy problems, AHP has significant physical plant deficiencies.
- By any modern standard of nursing home care, closure or replacement of AHP's physical plant would be warranted.
- The $170 million cost of replacement of AHP at its full licensed capacity of 889 beds, stated in AHP's pending Certificate of Need Application, may be significantly understated.
- As a part of the NHCC system, AHP contributes approximately 1,000 inpatient discharges to NUMC, with Medicare reimbursement to NUMC of approximately $10 million annually.[13]
- With a nursing home such as AHP in the NHCC system, NUMC should be better able to discharge expeditiously to AHP, patients no longer in need of acute care who may be difficult to place in other nursing homes, based on low acuity or other factors. Prompt discharges are important to NUMC because of adverse reimbursement consequences from retention of patients in the hospital beyond expected limits.
- There appears to be softness in nursing home occupancy in Nassau County and surrounding counties. Current trends toward home care and assisted living facilities and other alternatives continue to generate lower occupancy levels in nursing homes. As a result, there may be increased capacity for nursing homes to accept patients who otherwise would have gone to AHP.

[13] Medicare reimbursement is funded 100% by the Federal government, and does not include a County share. In contrast, Medicaid reimbursement is funded approximately 50% by the Federal Government, 25% by New York State, and 25% by the County.

B. Key Recommendations

1. Introduction

In addition to immediate recommendations described below, which are intended to improve AHP's financial performance, as well as longer-term recommendations, closure of AHP cannot at this time be ruled out as a viable option. It is therefore recommended that two options be pursued simultaneously over the next 18 months. The first option is to continue AHP as a nursing home, and follow the outlines of Strategic Option V, reducing AHP's size to between 450 and 680 beds, to be operated in a new facility to be constructed on the NUMC campus in East Meadow, subject to the configuration and contingencies described in detail below. Consistent with Strategic Option V, program configuration, shared services and management and professional affiliations should be explored as part of this option.

The second option to be explored is the closure of AHP, following transfer of AHP's patients to existing voluntary and proprietary nursing homes, which may have the capacity, and have expressed a willingness to accept those patients. The willingness of these providers to enter into appropriate transfer and affiliation agreements to address a range of concerns (e.g., expedited discharges from NUMC to the nursing homes, indigent care, etc.), and to maintain continuity of care for the patients at NUMC when inpatient care is required, would need to be confirmed.

Because each of the two options is subject to further factual investigation and negotiation with outside parties, as well as a number of contingencies, it is recommended that each be pursued and tested simultaneously over the next 18 months. Even if the reconstruction contemplated by the first option is ultimately chosen, pursuit of the second option will have provided greater insight into the extent that other nursing home placements are available, based on capacity at other nursing homes and the actual levels of acuity and other characteristics of AHP's patients. This inquiry will be very helpful in determining whether AHP should be closed, or alternatively, whether it makes sense for NHCC to incur the debt necessary to build a replacement for AHP. It also would provide valuable empirical data for the final sizing of the reconstructed AHP, to meet the need that cannot be met through patient transfers.

Under both of these options, the Uniondale property on which AHP is currently located should be cleared and sold. The proceeds of the sale of the 63 acres of property should be used to reduce or defease the outstanding $256 million debt. Sale of the Uniondale property also would have the salutary effect of returning this site to the local tax rolls, thereby reducing the tax burden on local taxpayers.

2. First Option: Construction of a 450-680 bed nursing home on the NUMC Campus

This option contemplates the construction of a replacement, hospital-based nursing home on NUMC's East Meadow campus, with a bed complement between 450 and 680 beds. As noted in the next section, it is recommended that the need for these beds be empirically evaluated and refined over the next 18 months.

A detailed architectural review of construction options is included in Exhibit F. For design and comparison purposes, the architects used the following bed configuration for a new nursing home:

Skilled nursing facility beds	480
Special Program and Sub-Acute beds:	200
20 Ventilator Dependent	
60 AIDS	
120 other sub-acute (potentially including rehabilitation, neurobehavioral, neurobiological, additional beds in the above-listed programs, or other sub-acute beds)	
Total Beds	680

The architectural review posits two potential alternative configurations for AHP on the East Meadow campus. In the first configuration, the Special Program and Sub-Acute beds would be constructed on four floors in the current NUMC main building (known as the Dynamic Care Building). Three of those floors are currently undeveloped, shell floors, and the fourth currently has temporary and other uses that could be redeployed elsewhere. The balance of basic nursing home beds would be constructed in a new five-story building behind the NUMC main building, connected by an underground tunnel and an aboveground bridge. The architectural review estimates the cost of construction of this configuration to be $92,397,915.

In the second configuration, the new building would be expanded to seven stories, and all of the beds would be contained in that new building. The architectural review estimates the cost of construction of this configuration to be $102,612,000, approximately $10 million more than the alternative that uses the three shell floors in the Dynamic Care Building. If the ultimate size of AHP is smaller than 680 beds, one or more floors in the new building could be eliminated.

In either configuration, the following contingencies would apply:

- Approval by the New York State Department of Health ("DOH") of a Certificate of Need Application, including: approval of the sub-acute specialty beds described above; approval of re-basing of AHP's reimbursement rates based on its status as a newly constructed "hospital-based" nursing home.

- Approval by the Federal Housing and Urban Development Agency (HUD) of Section 232 Mortgage Insurance. Such insurance would provide credit support for a tax-exempt bond issuance, subject to various requirements, including that the borrower be a separately incorporated entity.

If these contingencies cannot be satisfied within 18 months, our recommendation would be to close AHP.

3. Second Option: Transfer AHP Patients To Other Nursing Homes And Close AHP

The second option to be explored is the closure of AHP, following transfer of AHP's patients to existing voluntary and proprietary nursing homes. The County has been petitioned by the local nursing home association and by a small group of nursing homes, which have indicated that current nursing homes may have the capacity to absorb all or a significant number of the current occupants of AHP. The determination whether closure of AHP following transfer of AHP's patients to other nursing homes is warranted depends on a number of factors that must be explored and negotiated with the network of proprietary and voluntary nursing homes that have expressed an interest.

- First and foremost, is there truly sufficient capacity in these voluntary and proprietary nursing homes to accommodate AHP's current patients, and the projected future patients?

- Next, will those nursing homes be willing to enter into appropriate and enforceable transfer and affiliation agreements that will preserve ready access for timely discharge of patients from NUMC when they no longer require inpatient care? Such agreements would confirm the facilities' willingness to accept difficult patients who may be hard to place by traditional nursing home standards, their willingness to accept indigent patients to a defined level, and to maintain continuity of care when they require inpatient care.

- Finally, given the significant workforce dislocation that would occur upon a closing of AHP, would the nursing homes be prepared to evaluate AHP's nursing and support personnel, as warranted by the increased population in their facilities?

C. Immediate Steps For AHP

During the 18-month evaluation period, there are steps that can be taken to improve operations at AHP, cut costs, and increase revenues. These suggestions are excerpted from the report jointly developed with long-term care consultant Paul Rosenfeld and his staff who reviewed a sampling of charts and operations at AHP. Loeb & Troper provided assistance to Mr. Rosenfeld. The full Report concerning AHP is attached as Exhibit A.

Exhibit A provides in-depth factual support for a number of immediate steps, as well as longer-term recommendations in the event AHP does not close. The immediate steps are as follows:

- Improve PRI and MDS evaluations and other documentation, in order to assess actual acuity levels of each patient.

- Temporarily de-certify beds and thereby achieve 95% occupancy. Bed-hold reimbursement then would become available. Assuming 25 hospitalized patients every day, the reimbursement increase could be approximately $1.7 million annually.[14]

- Track and submit the necessary information to obtain bed-hold reimbursement in special program units.

[14] 25 patients per day X 365 days X $193 per day = $1.7 million annually.

- Seek DOH approval for “neurobehavioral” and/or “neurobiological” designation, which could cause an increase in CMI and reimbursement.

- Limit staffing to units that are occupied and seek to cluster more acute patients, and thereby reduce redundant staffing.

VII. Key Findings and Recommendations Regarding Ambulatory Care

This Section of the report reviews the role of the NUMC clinics and the seven NHCC DTC sites in delivering primary and specialty outpatient care. It draws on information contained in the Market Analysis; the "Financial Analysis of Reorganizing NHCC's Primary Care Programs" prepared by David Honig and Kim Harrison of the American Express Tax and Business Services Healthcare Services Group (Exhibit G); and the Physician Staffing Analysis (Exhibit J).

A. Background

Development of a sound strategy for the delivery of cost-effective outpatient services requires an understanding of the applicable licensure and reimbursement rules. These are discussed at some length in Exhibit K. However, in order to put the discussion that follows in context, we briefly summarize key aspects below.

Institutional primary and specialty outpatient care in New York State is generally delivered through the outpatient departments of hospitals licensed under Article 28 of the NYS Public Health Law or by Diagnostic and Treatment Centers ("DTCs") (community health centers) also licensed under Article 28 of the Public Health Law. NHCC delivers outpatient care under both types of licenses. Whether outpatient services are delivered under a hospital license or a DTC license has little implication for the type of care delivered, but it has enormous implications for the level of reimbursement under Medicaid fee-for-service, and the State's indigent care pools.

Since Medicaid is the most significant payer for outpatient services at NHCC, we start our overview with Medicaid. Hospital OPDs are reimbursed by Medicaid at a per-visit rate that has been capped at $67.50 since the early 1980s; DTCs are reimbursed at a generally higher cost-based, per visit rate, frozen since 1995. In both cases, capital costs are reimbursed on a cost pass-through basis. There is no reimbursement differential for Medicaid managed care visits. DTCs that are designated as federally qualified health centers ("FQHCs") are reimbursed under a third reimbursement methodology, based on the average of a center's 1999/2000 costs trended, on October 1 of each year, by the Medicare Economic Index. In addition, FQHCs are entitled to receive 100 percent of the difference between their Medicaid fee-for-service rates and the rates they receive from Medicaid managed care plans. With respect to Medicaid, FQHC rates are almost always the highest, while OPD reimbursement rates are always the lowest – by a substantial margin.

The second largest "payer" for outpatient services at NHCC is the State's Hospital and DTC Indigent Care Pools. Once again licensure drives the amount of reimbursement with very different results depending on whether these services are delivered under a hospital license or a DTC license. For public hospitals (unlike voluntary hospitals) the amount drawn from the Hospital Indigent Care Pool is fixed at the level the hospital received in 1996. By contrast, DTCs are subject to a hold harmless provision. A DTC may not receive less than it received in 1996. If the Center's indigent care need increases, however, it may receive more than its 1996 amount. For voluntary hospitals, it is almost always financially advantageous to deliver care to uninsured patients in an OPD rather than a DTC setting. For public hospitals, that is not necessarily true and a careful case-by-case analysis is required to determine the more fiscally advantageous setting.

As described in the next section, NHCC currently sees high volumes of Medicaid and uninsured patients at its Hospital OPD, and relatively low volumes in its DTCs. These findings together with the reimbursement differences described above have important implications for potential sources of new revenue for NHCC.

B. Key Findings

- Taken together, NUMC's outpatient clinics along with the NHCC DTCs are the family doctors for low-income and medically vulnerable residents of Nassau County who have limited access to private physicians.

- About 250,000 visits are made to the NUMC outpatient clinics annually, representing 25% of the County's hospital-based clinic visits. Approximately 57,000 visits a year are made to the seven NHCC DTC sites.

- NUMC is the dominant hospital-based provider of outpatient care to Medicaid and uninsured patients, and these patients are in turn the dominant source of outpatient volume at NUMC. Over 60% of the visits to the NUMC clinics are from Medicaid and uninsured patients.

- The NUMC OPDs provide approximately 60,000 primary care visits and 190,000 specialty visits per year. The seven NHCC DTC sites provide approximately 57,000 primary care visits per year.

- The volume of visits at the DTC has decreased while the volume at the NUMC OPD has increased, creating long waits at the OPD and other barriers to care.

- 78,000 visits are made to the NUMC clinics by Medicaid patients, for which NUMC is reimbursed at total of $75.12 per visit including capital; 11,800 visits are made to the seven DTC sites by Medicaid patients for which the NHCC receives $132.66 per visit including capital.

- Currently NUMC receives $7.5 million from the Public Hospital Indigent Care Pool or approximately 10 cents for every dollar of free care provided. The $7.5 million is fixed based on 1996 Bad Debt and Charity Care Distributions and does not vary as NUMC's actual indigent care volumes increase or decrease.

- Under the Health Care Reform Act's hold harmless provisions the NHCC receives a minimum of $3.2 million from the DTC Indigent Care Pool. Currently that equates to approximately 60 cents for every dollar of free care provided at its DTC sites. Unlike NUMC, NHCC DTCs receive an indigent care distribution that is not fixed; its annual distribution is based on uninsured visits delivered two years prior to its grant year. While under no circumstances can NHCC receive less than $3.2 million for free care, it can receive more.

- Using accepted physician productivity standards, physicians at the seven DTCs sites should be able to see twice as many patients as they are now seeing.

- With the exception of the Freeport-Roosevelt and Long Beach sites, the DTC physical plants are in reasonably good condition. (Facility Assessment Report, Exhibit F).

C. Key Recommendations

The data makes clear that the NHCC DTCs and OPDs are essential providers of primary care to Nassau County residents, and perform important public health functions for a significant segment of the County's Medicaid and medically indigent population. They should not be closed. Indeed, there is a strong justification for continuing and significantly expanding these facilities. However, a decision must be made whether NHCC should pursue its ambulatory strategy through an OPD or DTC license or the appropriate combination of the two. In addition, consideration must be given to appropriate program size, staffing and affiliation.

As noted above, it is recommended that the NHCC DTC and the NUMC clinics continue to operate, but be substantially restructured in accordance with the factors identified below. In the case of the DTCs, the restructuring should first address operational inefficiencies and lack of productivity, in order to prepare the DTCs to accommodate greater patient volumes. Next, marketing efforts in the relevant communities, and among the NUMC OPD patients should be undertaken to shift as much of the primary care volume to the DTCs, as compared to the OPDs. This would relieve overcrowding at NUMC, while increasing reimbursement by at least $50 per visit, a value of $1.25 million annually on 25,000 visits.

Beyond this immediate strategy, three more initiatives should be considered.

Step 1. Transfer the NUMC Primary Care Clinics to the NHCC DTC License.

Under this scenario, the hospital's primary care clinics would be transferred to the DTC license and a DTC site would be established on the NUMC campus. Transfer of the clinics would require the prior approval of the New York State Department of Health and an application seeking such approval should be filed early on.

Transferring the primary care clinics to the DTC license should increase annual revenue by at least $2.3 million. Approximately 20,000 primary care visits currently reimbursed by fee-for-service Medicaid at the clinic rate of $75.12 per visit would be reimbursed at NHCC's DTC rate of $132.66 per visit, with a reimbursement benefit of approximately $1.2 million. (This total could be increased, perhaps significantly, if some or all of the specialty clinic volume can be transferred to the DTC.) Furthermore, while NUMC's fixed Hospital Indigent Care Pool distribution would not change, NHCC DTCs would submit approximately $2.2 million in indigent care losses to the DTC pool, deriving approximately an additional $1.1 million of pool distributions.

Step 2. Seek FQHC Look-Alike Status.

It is recommended that the NHCC DTC apply for status as an FQHC look-alike. FQHC "look-alike" status is made available to health centers that do not receive funding under Section 330 of the Public Health Service, but meet all the governance and operational requirements of 330 grantees. To qualify for look-alike status, NHCC, as a first step, will have to come into compliance with the federal requirements with respect to governance of FQHCs. That means that NHCC will have to establish the DTC as a separate corporation, with a board where at least 51 percent are patients of the DTC. Alternatively, NHCC could set up a new not-for-profit corporation that would be established as a co-operator of the DTC The two entities would be co-operators of the DTC, but only the new corporation would be required to have a patient-controlled board.

FQHC rules would permit NHCC to retain authority with respect to personnel and budget matters. The two corporations would then jointly file for FQHC look-alike status.

As an FQHC, the health center would be eligible for certain benefits including enhanced Medicaid and Medicare reimbursement rates. The reimbursement benefit of this option is approximately $4.6 million. This is comprised of an increase in Medicaid fee-for-service reimbursement of $2.8 million, a $1.2 million increase in indigent care revenue, and $600,000 in Medicaid Managed Care wraparound payments.[15] As Medicaid managed care and Family Health Plus penetration increased, the value of the wraparound would likewise increase.

Step 3. Seek FQHC Grantee Status.

The third scenario contemplates that the DTC would apply for status as a 330 grantee, which can only be obtained through a nationally competitive application process. Grantee status provides two additional benefits beyond that of look-alike status: a grant of up to $600,000 per year, and Federal Tort Claims Act malpractice coverage for malpractice cases. In order to apply for FQHC look-alike or grantee status, the governance requirements described above would have to be met.

[15] The "wraparound payment" is the difference between an FQHC's negotiated rate with Medicaid Managed Care Plans, and its Medicaid rate.

VIII. Financial Implications Of Recommendations

A. Introduction

Developing, adopting and implementing practical approaches to the future programmatic and financial direction of NHCC is urgent and critical, given the current financial condition of NHCC, including its projected losses in 2004 and the likelihood that it will run out of cash by early 2005. This cash projection has been independently verified by the State and County Comptrollers and NHCC's own financial advisors. Immediate intervention is required now to avoid a precipitous financial collapse at NHCC and the ripple effects on Nassau County and its taxpayers.

The objectives of our examination were: to understand NHCC's financial performance and the factors that contribute to its poor performance; to identify areas for improvement in both revenue increases and expense reduction; and, to the extent that such improvement can be achieved, to reduce the level of County subsidies and derivative financial exposure.

There has been a "turnaround effort" underway over the past two years which has resulted in reducing the losses of NHCC significantly. Notwithstanding these efforts, NHCC continues to incur unsustainable losses. In December 2003, NHCC's Board of Directors and Management adapted the NHCC Budget for 2004. Prior to any adjustments intended to reduce the loss, the 2004 budget forecasts losses in excess of $35 million. The proposed adjustments include the recently implemented workforce reductions valued at approximately $18 million and a variety of initiatives to close the remaining gap. These include the following labor concessions being sought by NHCC's management in negotiations for a new union contract: employee contributions toward the cost of health insurance; reduction of 1-3 holidays; treating seven holidays as "floating," which would reduce overtime costs; providing overtime pay only after 40 hours of actual work; and reducing or foregoing wage/cost of living increases for 2003 and 2004.

These initiatives appear to be contingent, and may not be achievable. NHCC's CEO has indicated that an additional reduction of 300-400 hundred FTEs may be necessary to achieve a breakeven position in 2004. It should also be noted that the budget contemplates that the County subsidies and payments remain at their current levels.

The review of NHCC's financial performance was limited to utilization statistics, an examination of audited financial statements, certified cost reports submitted to third party payors, various audits performed by independent government and private auditors, the Cap Gemini reports and a number of specific studies and documents provided by NHCC's CFO and finance department staff. It should be noted that the CFO and his senior staff were cooperative, and were found to be experienced, knowledgeable, and hardworking professionals.

The discussion is organized as follows:

- Brief Financial History Of NHCC.
- Financial Implications By Enterprise.
- Summary Of Financial Impacts.
- Restructuring of the Relationship between Nassau County and NHCC.
- The $256 Million Bond Issue.

B. Brief Financial History of NHCC

Recapping briefly the financial history of NHCC, the transaction transferring NUMC, AHP and the County sponsored health centers was completed on September 29, 1999. As part of the transaction, NHCC issued $256 million of bonds backed by the guarantee of the County. From the proceeds of the bond issue, NHCC paid the County $82 million for the assets it acquired. The net value of the assets acquired was $136 million. The difference of $54 million was recorded as equity by NHCC. Included in the $136 million assets acquired by NHCC was $40 million in cash and cash equivalents. In addition, NHCC placed $135 million of the proceeds from the bond issue into an unrestricted operating fund for working capital.

From September 29, 1999 through August 31, 2003, NHCC has received more than $210 million in subsidies and payments from the County, yet NHCC had losses of $91.1 million comprised of:

- NUMC lost $76.4 million, 84% of NHCC's total losses.
- AHP lost $13 million.
- The DTCs lost $900,000, after taking into account $5 million annually in County subsidies for essential public health services, and $1.8 million annually in grants.

NHCC's cash position also has deteriorated. On December 31, 1999, NHCC had approximately $140 million of "Cash and Cash Equivalents." As of August, 2003, NHCC had approximately $40 million in Cash and Cash Equivalents. The State and County Comptrollers, and NHCC consultants, have predicted a cash crisis by early 2005.

C. Financial Implications by Enterprise

NUMC

As previously discussed, NUMC should identify, negotiate and execute a carefully structured professional affiliation and support services contract or contracts with one or more of the other Nassau County health care systems. These agreements may provide the opportunity to regionalize select health care services, provide clinical leadership and enhance recruitment, and, where appropriate, integrate Graduate Medical education and achieve significant savings through shared services arrangements, particularly for high cost clinical and information technology. Ultimately through these contractual affiliations NUMC will be able to provide substantially enhanced services to its patients. It is on this basis that NUMC's strategic and financial plan should be developed, as reflected in the key recommendations of this report.

Specifically, we have recommended that NUMC should:

- Revise its medical program to reflect its principal high volume core services, and further eliminate or regionalize non-core services.
- Reduce NUMC staffing to industry standards. After its recent staff reductions, NUMC is staffed at 5.16 FTEs per occupied bed. It should be staffed between 4.6 and 4.8 FTEs per occupied bed.

- Reduce physician staffing and/or modify physician financial arrangements to match the clinical volumes in each clinical department, utilizing appropriate productivity and compensation standards.

- Improve the revenue cycle by taking the necessary steps to capture required patient information, accurately document and code medical records, and bill and collect for all services, particularly emergency and ambulatory care services.

- Eliminate or reduce the size of the non-core graduate medical education teaching programs and related attending faculty.

- Participate in Public Health Service Act §340B program. As a disproportionate share hospital, NUMC is qualified to participate in this statutory program, which permits deep discounts on both brand name, generic and over-the-counter drugs.

The following chart summarizes the financial implications of the Recommendations for NUMC.

Item	Time Frame	Estimated Annual Financial Impact, Once Implemented
Improve documentation of patient acuity, with potential increase in CMI	2-3 months	Subject to further study. Each .01 increase in CMI at NUMC is estimated to be worth approximately $1.2 million in annual Medicaid and Medicare reimbursement.
Reduce NUMC staffing per occupied bed from the current 5.16 to between 4.6 and 4.8	2-3 months	$10.3 – 15.3 million 4.6: reduce 313 FTEs = $15.3 million. 4.8: reduce 204 FTEs = $10.3 million
Savings from Physician Staffing reductions, in addition to reductions implemented in 2003	2-3 months	$3.7 million Estimated savings of $3.7 million are based on the Physician Staffing Analysis (Exhibit J), which indicated that further study would be needed to determine whether reductions in staffing could be achieved in the Operating Rooms and Ancillary Departments. Additional savings also might be achieved in conjunction with elimination or modification of staffing arrangements for non-core services.

Item	Time Frame	Estimated Annual Financial Impact, Once Implemented
Improve Revenue Cycle	Immediate	$4.3 million The Cap Gemini study of NUMC's revenue cycle identified potential revenue increase of $14.3 million. Administration has reported that approximately $10 million has been achieved, leaving $4.3 remaining. Additional revenue increases could be achieved through continuation of these efforts at NUMC, and application of similar efforts at the DTCs and AHP.
Improve utilization controls and reduce length of stay	2-3 months	Subject to further analysis and estimation as part of the implementation process.
Affiliate with strong healthcare network 1. Reorganization of select clinical services. 2. Unifying management and administration of clinical departments under a common clinical chair. 3. Provision of attending physician staff for all or some of the clinical departments. 4. Integration of all or some of the graduate medical education/residency training programs. 5. Turnkey management of select administrative and clinical departments.	6-9 months.	Subject to further analysis and estimation as plans are developed for such affiliations and regionalization of services.
Other restructuring of clinical and teaching programs to fit with NUMC's role as a community hospital.	6-9 months	Subject to further analysis and estimation as plans are developed for such restructuring.
Participate in Public Health Service Act Section 340B Program	Immediate	$1.2 million Minimum discounts of 15.1% from Average Manufacturer Price for brand name drugs, and 11% from Average Manufacturer Price for generic and over-the-counter drugs. NUMC has begun implementation, and has estimated its value as $1.2 million.

AHP

There are three distinct initiatives that must be examined over the next 18 months, to determine the future of AHP.

First:

- Continue AHP at its current location. Immediately reduce its licensed capacity from 889 beds to 650 beds. Seek regulatory approval to expand or establish HIV, ventilator dependent and other specialty skilled nursing units that bring higher reimbursement.

- Seek "bed hold" reimbursement occasioned by the reduced licensed capacity.

- Consolidate nursing units and reduce current staffing to conform to industry staffing standards.

- Undertake whatever facilities improvements may be necessary to assure the safety and comfort of the current residents. The current facility is likely to be in use for at least 18 months and possibly up to 4 years, to permit any replacement to be financed and constructed.

Second:

Continue to plan for the replacement of AHP with the following changes to the current plan:

- The new facility should be planned for 480 to 680 licensed beds. The final bed size should reflect the results of negotiations with other providers regarding their capacity and willingness to accept NUMC referred patients.

- Plan to construct the replacement on the East Meadow campus. The Architectural Review concluded that 200 beds can be constructed in existing Dynamic Care Building, NUMC's utilizing three vacant shell floors and other underutilized floors. The remaining beds can be constructed in a separate free standing building immediately adjacent to NUMC.

- Financing for the new facility should be undertaken only if Federal mortgage insurance under the §232 program is obtained.

- The AHP property in Uniondale should be sold and the proceeds should be utilized to reduce the $256 million debt.

Third:

- Commence immediate negotiations with other nursing home providers to determine their capacity and willingness to accept AHP patients and future NUMC referrals.

The following chart summarizes the financial impact of the recommendations for AHP.

Item	Time Frame	Estimated Annual Financial Impact, Once Implemented
Pursue regulatory approval to increase HIV specialty unit from 20 beds to 36 beds	2-3 months	Additional revenue of $1.5 million
Improve PRI and MDS evaluations and documentation, with potential to increase CMI, and to determine whether patients fit into specialized categories (HIV, etc.)	2-3 months	Estimate would require more in-depth study of coding for each patient. Each .01 increase in CMI would result in an annual increase in Medicaid reimbursement of $500,000.
Seek certification of a neurobehavioral and/or neurobiological units, to the extent justified by revised PRI and MDS evaluations.	3-6 months	No estimate is provided because this item is contingent on regulatory approvals. Neurobehavioral designation would provide a CMI increase of 1.4 and a rate increase of $142.14 per patient day, subject to increased costs of providing care.
Consolidate nursing units and staff from 1.21 per bed to 1.0 or 1.1.	2-3 months	1.0: reduce 137 FTEs = $6.8 million. 1.1: reduce 71 FTEs = $3.6 million.
De-certify beds to achieve 95% occupancy and obtain bed hold reimbursement, including in specialty units.	2-3 months	Additional revenue of $1.7 million Annual estimated increase of $1.7, based on current level of 25 hospitalized patients at all times. Benefit may be greater for specialty unit patient bed holds.
Seek hospital-based status for new nursing home, if constructed	18 months	480 beds (assuming 95% occupancy and, rebasing at ceilings, without increased rates for specialty beds[16]): Additional revenue of $5.8 million. 680 beds (assuming 95% occupancy): Additional revenue of $8.3 million.
Sell Uniondale property, following closure or relocation of AHP to the East Meadow campus.	2 years	One-time revenue of $30-70 million Estimated value depends on zoning variances and other factors. An independent appraisal was beyond the scope of the study.

[16] AIDS and other specialty beds would have an additional increase in the daily rate, but the number of such beds that will be approved cannot be determined at this time.

Ambulatory Care Network

NHCC should:

- Reorganize all ambulatory care services under a common corporate licensure and management structure utilizing its Diagnostic and Treatment Center licenses to provide these services. By definition, NUMC's DTCs have Medicaid reimbursement rates in excess of at least $50 per visit higher than the current statutory capped Medicaid rate at NUMC's OPD.

- Explore the feasibility of obtaining FQHC lookalike or FQHC grantee status for the DTC organization.

- The eighty-one separate NUMC outpatient clinics should be consolidated and, to the extent possible, be operated under the DTC structure.

- Following triage, all emergency room patients who do not present true emergencies should be seen in the appropriate clinic/DTC setting, including redirecting them to the health centers nearest their homes.

- Operationally, the clinics and health centers must provide for a more effective scheduling of appointments and coordination with ancillary departments and specialty clinics at NUMC.

- NHCC must undertake an aggressive educational and marketing effort to advise the community on the appropriate usage of the emergency room and the availability of primary and specialty services at the DTCs.

- The DTCs (clinic and health centers) must be fully integrated into the teaching programs.

- As discussed in more detail in the chapter on Ambulatory Care Network, all primary care outpatient clinics should be transferred to the DTC structure as more fully described in Exhibit G relating to the creation of Ambulatory Care Network and its subsequent transition to FQHC status.

- DTC Staffing levels should be reduced to industry standards, to the extent additional volume is not realized over the next three months.

The following chart summarizes the financial impact of the recommendations for the Ambulatory Care Network.

Item	Time Frame	Estimated Annual Financial Impact, Once Implemented
Restructure OPDs as part of DTCs	3-6 months	Additional revenue of $2.3 million Estimated revenue increase is based on the approximately $50 higher per visit DTC rate that would apply to NUMC visits after restructuring. Reduce staffing at the DTCs to industry norms if increased volumes are not achieved in the next three months.
Apply for FQHC designation for DTCs	6-9 months	Additional revenue of $4.6 - $5.0 million FQHC "lookalike" status = $4.6 million FQHC "grantee" status = $5.0 million

General

The following chart summarizes the key recommendations regarding NHCC generally. As noted in the Chart, estimates of economic impact of these changes requires further study.

Item	Time Frame	Estimated Annual Financial Impact, Once Implemented
Amend Enabling Legislation	3-6 months	Estimates are not included, pending development of proposals and further study.
Restructure Governing Board	Immediate	Estimates are not included, pending development of proposals and further study.
Participate in group purchasing	2-3 months	Estimates are not included, pending development of proposals and further study.
Consider outsourcing a number of functions, particularly those which require enhanced Information Technology Services	3-6 months	Estimates are not included, pending development of proposals and further study.

D. Summary of Financial Impacts

The summary chart below summarizes the range of potential cost savings and revenue increases for each NHCC enterprise, where estimates are available. Detailed supporting charts follow.

1. Workforce Reductions

Enterprise	Cost Savings	Revenue Enhancement
NUMC	($14-19 million)	
AHP	($3.6-6.8 million)	
Ambulatory Care Network	N/A	
Total	($17.6-25.8 million)	

2. Operational Improvements

Enterprise	Cost Savings	Revenue Enhancement
NUMC	($1.2 million)	$5.5-14 million
AHP		$9.5-14 million
Ambulatory Care Network		$6.9-7.3 million
Total	($1.2 million)	$21.9-35.3 million

3. Labor Concessions[17]

Enterprise	Cost Savings	Revenue Enhancement
NHCC and all enterprises combined	($13.9-20.7 million)	

Total (excluding One-Time Item)	($32.7-47.7 million)	$21.9-35.3 million

4. Debt Reduction

Enterprise	Cost Savings	Revenue Enhancement
Sale of Uniondale real estate, with proceeds of $30-70 million applied to debt reduction	($2-5 million)	

[17] These figures reflect labor concessions being sought by NHCC's administration.

Entity/Item	Timeframe [18]	Cost Savings - Low	Cost Savings - High	Revenue Enhancement - Low	Revenue Enhancement - High
NUMC					
1. Workforce Reductions					
Reduce staffing per occupied bed from 5.16 FTEs to 4.6 (reduce 313 FTEs) or 4.8 (reduce 204 FTEs)	Short-Term	($10,300,000.00)	($15,300,000.00)		
Physician Staffing Reductions (20.49 FTEs, per physician staffing analysis)	Short-Term	($3,700,000.00)	($3,700,000.00)		
Subtotal		($14,000,000.00)	($19,000,000.00)	N/A	N/A
2. Operational Improvements					
Improve revenue cycle (Cap Gemini Report identified $14.3 million, of which $10 million has been achieved)	Short-Term			$4,300,000.00	$8,000,000.00
PHS Section 340B Drug Discount Plan	Short-Term	($1,200,000.00)	($1,200,000.00)		
Improve documentation of patient acuity, with potential increase in CMI Each .01 increase in CMI at NUMC is estimated to be worth approximately $1.2 million in annual Medicaid and Medicare reimbursement	Short-Term			$1,200,000.00	6,000,000.00
Subtotal		($1,200,000,00)	($1,200,000.00)	$5,500,000.00	$14,000,000.00
3. Labor Concessions See NHCC chart for items applicable to all enterprises.					
Total NUMC		($15,200,000.00)	($20,200,000.00)	$5,500,000.00	$14,000,000.00

[18] Short-Term (3-6 months); Medium-Term (6-18 months); Long-Term (more than 18 months); One-time.

Entity/Item	Timeframe[14]	Cost Savings - Low	Cost Savings - High	Revenue Enhancement - Low	Revenue Enhancement - High
AHP					
1. Workforce Reductions					
Consolidate nursing units and staff appropriately; reduce staffing from 1.21FTEs per bed to 1.0 (reduce 137 FTEs) or 1.1 (reduce 71 FTEs).	Short-Term	($3,600,000.00)	($6,800,000.00)		
Subtotal		($3,600,000.00)	($6,800,000.00)		
2. Operational Improvements					
HIV Unit - increase by 16 beds, pursuant to pending application, awaiting State DOH approval	Short-Term			$1,500,000.00	$1,500,000.00
Decertify beds and achieve bed-hold reimbursement for approximately 25 AHP patients who are hospitalized each day.	Short-Term			$1,700,000.00	$1,700,000.00
Improve PRI and MDS evaluations and documentation, with potential to increase CMI, and to determine whether patients fit into specialized categories (HIV, etc.). Each .01 increase in CMI would result in an annual increase in Medicaid reimbursement of $500,000.	Short-Term			$500,000.00	2,500,000.00
Seek hospital-based status and re-basing to ceilings upon construction of replacement facility (nursing bed rate assumed for all beds; benefit would increase for specialty beds)	Long-Term			$5,800,000.00	$8,300,000.00
Subtotal		N/A	N/A	$9,500,000.00	$14,000,000.00
3. Labor Concessions See NHCC for items applicable to all enterprises.					
4. One-time Item					
Sell Uniondale Property for $30 - $70 million (appraisal not performed)	One-Time				
AHP Total (excluding one-time item)		($3,600,000.00)	($6,800,000.00)	$9,500,000.00	$14,000,000.00

Entity/Item	Timeframe[14]	Cost Savings - Low	Cost Savings - High	Revenue Enhancement - Low	Revenue Enhancement - High
Ambulatory Care Network					
1. Workforce Reductions					
Not recommended at this time; however, DTC Staffing levels should be reduced to industry standards, to the extent additional volume is not realized over the next three months.	Medium-Term				
2. Operational Improvements					
Restructure OPD as part of DTCs and receive higher DTC reimbursement rate	Short-Term			$2,300,000.00	$2,300,000.00
Apply for FQHC Lookalike and/or Grantee status	Medium-Term			$4,600,000.00	$5,000,000.00
Subtotal				$6,900,000.00	$7,300,000.00
3. Labor Concessions See NHCC for items applicable to all enterprises.					
Ambulatory Care Network Totals		N/A	N/A	$6,900,000.00	$7,300,000.00

Entity/Item	Cost Savings - Low	Cost Savings - High	Revenue Enhancement - Low	Revenue Enhancement - High
NHCC -All Enterprises Combined -- Labor Concessions[19] (NHCC Estimates)				
Employee contributions toward health insurance	($4,600,000.00)	($7,600,000.00)		
Reduction of 1-3 holidays	($ 250,000.00)	($ 750,000.00)		
Treating 6 holidays as floating, which would reduce overtime costs (savings of $250,000 per day)	($ 250,000.00)	($1,500,000.00)		
Provide overtime pay only after 40 hours of actual work	($3,000,000.00)	($5,000,000.00)		
Salary savings if no wage/cost of living increases for 2004	($5,835,000.00)	($5,835,000.00)		
Salary savings if no wage/cost of living increases for 2003 (approx. $6,000,000.00)[20]	-0-	-0-		
Total	($13,935,000.00)	($20,685,000.00)		

[19] These figures reflect labor concessions being sought by NHCC's administration.
[20] NHCC has assumed no increase for 2003.

As described in detail throughout this report, the following initiatives should be pursued at each enterprise. It is expected that these initiatives will yield significant cost savings and revenue enhancements, over time, but estimates cannot be accurately made in the absence of further analysis as implementation begins.

NUMC

- Improve utilization controls and reduce length of stay.

- The eighty-one separate NUMC outpatient clinics should be consolidated and, to the extent possible, be operated under the DTC structure.

- Operationally, the NUMC clinics must provide for a more effective scheduling of appointments and coordination with ancillary departments and specialty clinics at NUMC.

- Following triage, all emergency room patients who do not present true emergencies should be seen in the appropriate clinic/DTC setting, including redirecting them to the health centers nearest their homes.

- Undertake an aggressive educational and marketing effort to advise the community on the appropriate usage of the emergency room and the availability of primary and specialty services at the DTCs.

- Affiliate with strong healthcare network:

    1. Reorganization of select clinical services.

    2. Unifying management and administration of clinical departments under a common clinical chair.

    3. Provision of attending physician staff for all or some of the clinical departments.

    4. Integration of all or some of the graduate medical education/residency training programs.

    5. Turnkey management of select administrative and clinical departments.

    6. Other restructuring of clinical and teaching programs to fit with NUMC's role as a community hospital, subject to further analysis and estimation as plans are developed for such restructuring.

AHP

- Seek State Department of Health approval of neurobehavioral and/or neurobiological designation, to the extent justified by the revised PRI and MDS evaluations. Neurobehavioral designation would provide a CMI increase of 1.4 and a rate increase of $142.14 per patient day, subject to increased costs of providing care. No estimate is provided because this item is contingent on regulatory approvals.

Ambulatory Care Network

- Operationally, the health centers must provide for a more effective scheduling of appointments and coordination with ancillary departments and specialty clinics at NUMC.
- The DTCs (clinic and health centers) must be fully integrated into the teaching programs.

NHCC Generally

- Amend Enabling Legislation.
- Restructure Governing Board.
- Participate in group purchasing.
- Consider outsourcing a number of functions, particularly those which require enhanced Information Technology Services.
- Impose limits on accruals of vacation, sick and compensatory time.
- Independently audit all accrued vacation, sick leave and compensatory time.

E. Restructuring Of The Relationship Between Nassau County And NHCC; Key Findings And Recommendations

Implementation of the Recommendations, which will involve business planning, modification of program scope, physician staffing, potential affiliations and many other changes, invites restructuring of the provisions of the Acquisition Agreement and the Services Agreements between NHCC and Nassau County. As noted above, the basic flaws in these agreements also support their re-negotiation.

Restructured contractual arrangements involving services should contain precise definitions of all services to be provided, should address qualitative and quantitative concerns, should impose productivity standards, and should provide for verification and audits of services provided. Compensation provisions should be well-defined, based on industry standards and norms, and should not include hidden subsidies.

Provisions regarding County subsidies should be limited to well-defined purposes, and quantified in amounts. To the extent that subsidies are intended to address free care or charity care, the amount of the subsidy should be linked to the reasonable cost of providing the free and charity care, without reference to other losses that NHCC may incur due to excessive costs. All such provisions also should be distinguished from any accounting artifacts that may accompany Bad Debt and Charity Care Reimbursement.

A reasonable approach will need to be negotiated with respect to the purported County commitment to fund certain capital costs, including corrective steps or improvements to facilities. This approach should incorporate a practical assessment of the facilities issues, with reasonable phasing of projects over time, in accordance with NHCC's capital budget. The costs of remediation claimed by NHCC have not been verified.

Finally, in connection with the modification of the agreements, the disputes concerning historic amounts claimed to be "due to" or "due from" NHCC and Nassau County should be reconciled and resolved in accordance with the renegotiated framework for service provision and payment.

NHCC's financial performance over the past four years has also been artificially enhanced through a variety of payments provided by the County pursuant to the Acquisition Agreement and other Service Agreements. These payments do not reflect a reasonable basis for compensating NHCC for the services it provides. In 2003, the total County payment, exclusive of the County's share of Medicaid, was $52 million. Once the restructuring of programs, cost reductions and revenue increases are achieved, and reasonable principles of reimbursement are applied, it may be possible to apply surpluses toward debt reduction.

F. 1999 $256 Million Bond Issue

This section addresses the question posed earlier:

> How should Nassau County and NHCC address the financial legacy imposed by the $256 million bond issue and other financial obligations undertaken by the County in connection with the creation of NHCC (e.g., historic borrowings, pension and other employee-related costs), including development of strategies for reducing and extinguishing those obligations over time, and through restructuring of the operations of NHCC, to the extent permitted by law and agreement?

As previously described, on September 29, 1999, pursuant to Article 10-C Title 2 of the New York Public Authorities Law (sections 3400-3420, hereinafter the "Act") the Nassau Health Care Corporation (NHCC) issued its bonds (the "Bonds") in the principal amount of $259,734,845.[21] The nature and terms of the 1999 $256 million Bond Issue have been reviewed in order to determine the nature and scope of the obligations assumed by NHCC and Nassau County. A full description is provided in the 1999 Bond Issue Summary, attached as Exhibit D.

Unfortunately, review of the terms of the 1999 Bond Issue reveals that there is very little immediate flexibility concerning elimination or re-financing of the debt. However, the following steps are recommended:

- Upon closure of AHP or re-building of AHP on the East Meadow Campus, the proceeds of sale of the Uniondale property should be dedicated to reduction of the NHCC debt.

- Restructuring options have been reviewed with the Deputy County Executive For Finance, the County Treasurer and their advisors, the PFM Group. A copy of a preliminary analysis by the PFM Group is attached as Exhibit C. The PFM analysis identifies potential savings that are highly variable, depending on market conditions. These options should continue to be developed and implemented if deemed appropriate and financially advantageous.

[21] Referred to as $256 million, based on certain adjustments.

IX. Personnel Administration And Labor Relations

Key Findings and Recommendations regarding the management structure, table of organization, and qualifications are addressed in Chapter XI of this report.

Key Findings and Recommendations related to Physician Staffing, productivity and compensation are addressed in Chapter V of this report.

With respect to all other positions, the scope of this Study did not encompass a departmental review of staffing. The recommendations with respect to the appropriate staffing of the Hospital are predicated on an examination of the scope and volumes of clinical and support services, utilizing reasonable productivity standards. However, NHCC did not initially have or develop the modern management systems, including related information technology, needed to effectively capture relevant information to assist managers in budgeting, scheduling and tracking personnel on a timely basis. The Kronos time-keeping system is being installed, and may represent the beginning of the process.

Similarly, personnel records generally are maintained manually. Among the more alarming and financially troubling aspects of personnel policies and administration are the accumulation of accrued vacation, compensatory time and sick leave benefits. The value of these accrued liabilities for NHCC is estimated at $70 million. Pursuant to the Acquisition Agreement, Nassau County is obligated to pay up to $50 million of its pro rata share of these obligations for those NHCC employees who were formerly County employees and transferred to NHCC. The ability to accrue these benefits derives from historic collective bargaining agreements that permit accruals of up to 200 days, including vacation time, conversion of unpaid sick leave, and compensatory time earned at 1-1/2 to 2 times for holidays. Unfortunately, the amounts accrued appear to have accelerated since the creation of NHCC, with a growing financial impact on NHCC, and potentially, on the County.

In their interviews, senior managers consistently referred to the application of the Civil Service Law to the workforce as generating significant impediments to effective management. Coupled with the fact that virtually the entire workforce, including managers, are included in the bargaining unit represented by CSEA, and therefore enjoy the same benefits program, there does not appear to be a clear and effective delineation and exercise of management responsibilities with respect to controlling the costs of these benefits, on the general theory that a “rising tide raises all ships.”

The following recommendations are discussed elsewhere in this report:

- Creation of Internal Civil Service Commissioner/Senior Vice President Personnel Administration.

- Creation of a management tier excluding management titles/positions from collective bargaining units.

The following additional steps are recommended:

a. Establish a table of titles with job descriptions and qualifications specific to healthcare providers.

b. Independently audit all accrued vacation, sick leave, compensatory time benefits.

c. Require that all employees can accrue no more than two years entitlement of accrued time from all sources.

d. Require all employees to begin using their vacation and other accrued time, until they come within the two year limit.

e. The NHCC employees, while represented by CSEA, are in a separate bargaining unit. NHCC has also identified a number of labor concessions which it is attempting to negotiate as part of its new collective bargaining agreement.

X. NHCC's Facilities And Related Real Estate and Capital Budget.

A review of buildings and related real estate was undertaken. The purpose of this review was to provide an assessment of the general condition of all the buildings owned and/or leased by NHCC, to determine their suitability for accommodating the current programs and uses; to determine what, if any, changes in use were architecturally desirable to accommodate the program restructuring contemplated by the relocation of the AHP to the East Meadow Campus, and to evaluate the various buildings with respect to the need for capital improvements.

This review was performed by RBSD Architects, an architecture firm with extensive experience in hospital, nursing home and ambulatory care planning and construction. A copy of their full report is attached as Exhibit F. The report includes a detailed profile of NUMC's Dynamic Care Building and each building on the East Meadow campus, AHP and six of the seven Community Health centers. In addition they have specifically confirmed the architectural feasibility of relocating AHP to the East Meadow campus.

A variety of source documents were utilized in the review, including:

- Facilities Master Plan for NUMC and AHP dated April 1994 Vol. 1-4.
- Site and stack diagrams for all buildings.
- NUMC Existing Facility and Condition Report dated August 29, 2002.
- Capital Obligation Report Ruskin Moscow Faltischek P.C. dated July 29, 2002 (unverified).

A. Facilities Key Findings

Without enumerating the specific findings relating to each building and land use, the following is a summary:

1. NUMC. The Dynamic Care building and related hospital buildings are usable, but require remediation of certain code deficiencies.

2. AHP. AHP is seriously inadequate to function as a modern long term care facility; it is beyond remediation.

3. Ambulatory Care Centers. Generally, four of the six health centers, with some refurbishment, can continue to be used, subject to meeting utilization and productivity assessments. The physical plants of Freeport-Roosevelt and the Long Beach Community Health Centers are severely deficient in all respects and should be relocated, consolidated with other health centers, or closed.

B. Facilities Key Recommendations

- The proposal to relocate AHP to the East Meadow Campus as set forth in this report is architecturally feasible.

- Given that NHCC has no capital debt capacity, and given the high level of subsidy required from the County and the continuing impact on the County and its taxpayers, any further investment must be guided by the following principles:

    a. Any expenditures for capital plant and equipment at NHCC should be limited and prioritized to:

        (i) Remedy life safety code requirements and/or violations.

        (ii) Be necessary and documented to generate revenues or reduce operating costs.

        (iii) To the maximum extent possible, any future capital investments must be reimbursed by third party payors.

    b. No further deficit funding should be undertaken which further exacerbates the tenuous financial position of NHCC.

- The financing of a replacement facility for AHP must qualify for Section 232 FHA Mortgage Insurance, and not rely on Nassau County guarantees.

XI. Corporate Restructuring Governance and Management

A. How To Restructure NHCC

1. Introduction

In this section, we address the following questions, posed at the outset of the Study:

> If some or all of these enterprises are to continue, how should they be reorganized, to fulfill a defined mission in an efficient and financially viable manner?
>
> Specifically, what, if any changes should be made to address issues of governance, management, operations and finance, including the size of the financial support required to preserve and support NHCC and its operating enterprises as a financially viable public agency?

In order to clearly define and describe the restructuring recommendations, it is important to note that the recommendations involve multiple levels of change, some of which require amendment of NHCC's enabling statute, and others that can be implemented in accordance with the existing statutory and other authority. Our findings and recommendations are organized into the following subject matter categories:

- Corporate restructuring of NHCC and its three enterprises or operating divisions.
- Statutory and legal changes related to the corporate restructuring and improved functioning of NHCC and its three enterprises.
- Obligations of NHCC's Governing Board.
- Changes to the Administrative/Management structure of NHCC and its three divisions.

B. Corporate Restructuring Of NHCC And Its Three Enterprises

The recommended corporate restructuring of NHCC and its three operating divisions is designed to achieve two critical objectives. First, to make NHCC more accountable and responsive to Nassau County elected and appointed officials. Second, to organize, manage, govern, operate and finance each of the three NHCC enterprises more effectively.

As noted earlier, NHCC is a public benefit corporation created by special act of the New York State Legislature under the New York State Public Authorities Law. The purposes of NHCC are essentially to perform a local function of operating an entirely local health care system. Given their history, Nassau County and NHCC are inextricably bound together with respect to County health care policy concerns, and certainly with respect to NHCC's finances. Currently, except for the role of the County Executive and County Legislature in appointing and nominating candidates to the NHCC Board of Directors, and the County Executive's appointment of the Chairman of the Board and approval of the CEO, NHCC is independent, and has functioned independently of elected and appointed County officials. As a matter of State and County policy, NHCC should be made more accountable and responsive to local executive and

legislative policy direction, particularly programmatically and financially, given the County's continuing financial exposure under its guarantee of the 1999 Bond Issue.

1. Retention of Select Powers

Given the nexus between Nassau County and NHCC, a direct parallel can be drawn with the powers and authority that are generally reserved by members of hospitals organized under the New York Not-For-Profit Corporation Law ("NPCL"). Although many not-for-profit or "voluntary" hospitals are governed by self-perpetuating Boards of Directors, it also is common for voluntary hospitals to be structured as membership corporations. For purposes of hospital establishment, the New York State Department of Health treats members as either "passive" or "active," based largely on the concepts embodied in the New York Not-for-Profit Corporation Law (the "N-PCL"). Under the N-PCL, a member is analogous to a stockholder in a business corporation. Although members in a not-for-profit corporation do not have ownership interests in the entity, they elect the Board of Directors and have approval rights over amendments to the Certificate of Incorporation and By-Laws, and with respect to transfer of all or substantially all of the assets, or merger, consolidation or dissolution of the corporation. An entity that serves as the sole member of a not-for-profit corporation is sometimes referred to as the "parent" of the corporation. A member who exercises only those rights expressly authorized under the N-PCL is viewed by New York State Department of Health regulations as a "passive" member, and Article 28 establishment is not required.

However, under Section 701(b) of the N-PCL, a not-for-profit corporation, in its Certificate of Incorporation, may vest some or all of the management of the corporation in the member. If the management of an Article 28 facility is delegated to a member, rather than the Board of Directors, the Department of Health regulations view such a member as an "active" member, required to be established as the facility's operator.

Specifically, Section 405.1(c) of the Department of Health Regulations provides the following list of powers that, if delegated to any entity, require Article 28 establishment of the entity:

a. appointment or dismissal of hospital management-level employees and medical staff;

b. approval of hospital operating and capital budgets;

c. adoption or approval of hospital policies and procedures;

d. approval of certificate of need applications filed by or on behalf of the hospital;

e. approval of hospital debt necessary to finance the cost of compliance with operational and physical plant standards required by law;

f. approval of hospital contracts for management or for clinical services; and

g. approval of settlements of administrative procedures or litigation to which the hospital is a party, except approval by the members of a not-for-profit corporation of settlements of litigation that exceed insurance coverage or any applicable self-insurance fund.

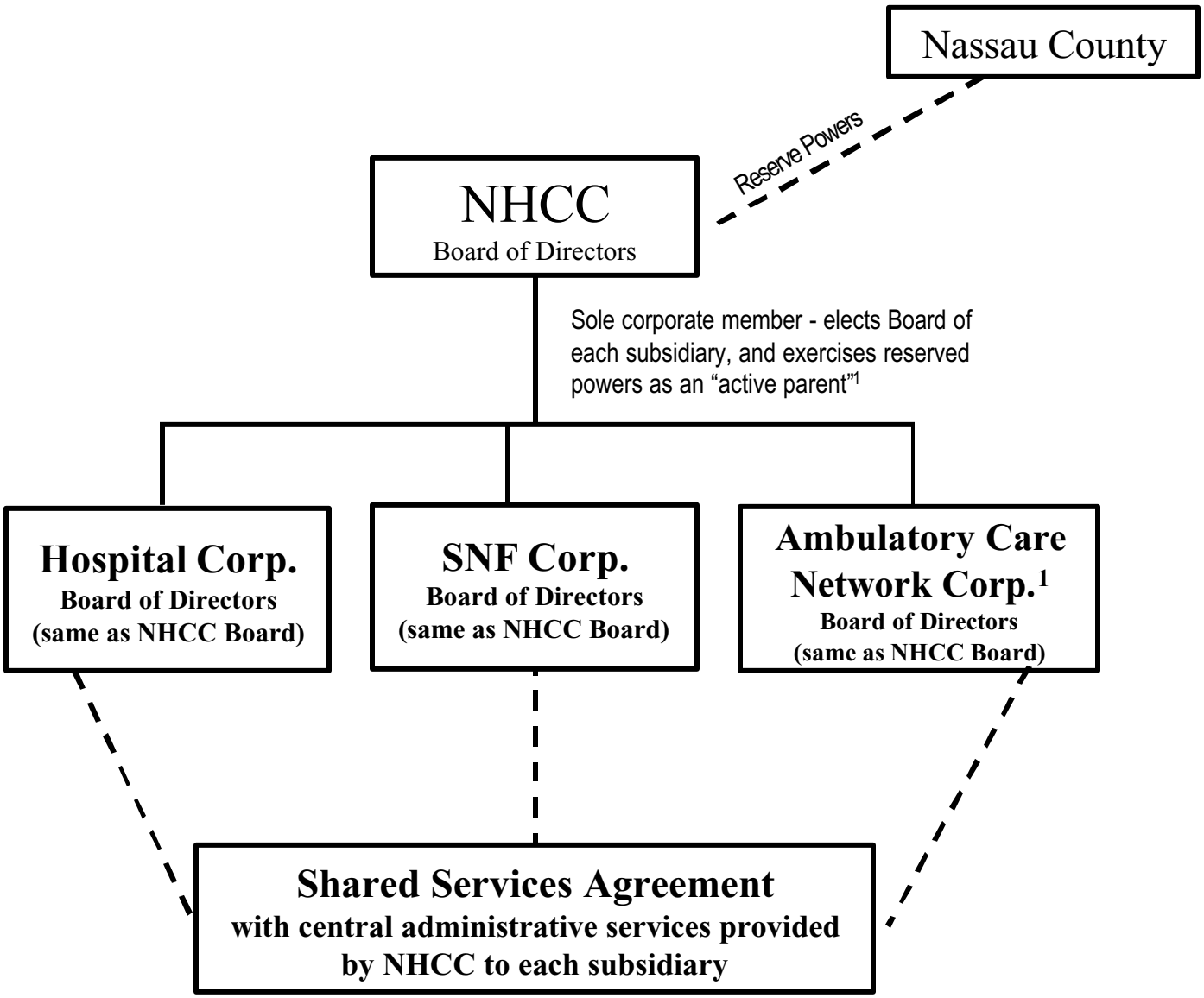
Upon creation of the subsidiaries, we recommend that NHCC retain all of the powers of an active member. In addition, we recommend that NHCC's enabling statute be amended to provide the County with the Board appointment authority and management approvals described below, and to reserve to the County the power to approve NHCC's annual operating and capital budgets. Finally, the County Executive should retain the power to remove the Board if removal is in the best interest of the County.

2. Creation of Subsidiaries

NHCC's three enterprises differ from each other in a number of important respects, including highly distinct purposes, different applicable Federal and State laws, rules and regulations, different accreditation requirements, different financing and reimbursement mechanisms for both operating and capital needs, and significantly different day-to-day operating and staffing requirements. While the proposed corporate restructuring would create three separate entities, management and operational efficiencies would be addressed through shared services agreements both within the NHCC system, and, potentially, as part of management and professional affiliations.

While the current corporate structure of NHCC is not necessarily an impediment to governing and managing each enterprise, the level of attention by the governing board and management to each enterprise has been deficient in the current structure. Pursuant to the recommended restructuring, each enterprise could be governed and managed appropriately, and specific planning and focus on their programs could be achieved as they go through their respective transformations. In addition, the recommended corporate restructuring anticipates the need to create subsidiary corporations, as currently authorized by NHCC's enabling statute, in order to pursue specific reimbursement, grant funding and capital financing opportunities for each of the enterprises, as more fully described in the sections below relating to AHP and the Ambulatory Care Network.

As shown in the diagram below, we are recommending that a new subsidiary corporation be created for each enterprise, as permitted under the current NHCC enabling statute. Assuming the recommended changes are made in the NHCC corporate structure, we recommend that the NHCC Board elect the Subsidiary Boards, subject to approval by the County Executive. At least initially, we recommend that the Board of each subsidiary be identical to the NHCC Board. Finally, Nassau County should be granted the reserve powers enumerated above.



[1] Federally Qualified Health Center designation may require further changes in the corporate structure of this subsidiary.

C. Statutory And Legal Changes Related To The Corporate Restructuring And Improved Functioning Of NHCC And Its Three Enterprises.

To accomplish accountability and responsiveness, we recommend the following changes to NHCC's enabling statute:

1. Governance

a. Current Structure

Currently, NHCC's enabling statute provides for NHCC to be governed by a Board of Directors with 15 members, appointed as follows:

Appointing Person or Entity	Number	Recommendation	Initial Term	Subsequent Term
Governor	1	Upon the recommendation of the County Executive.	4 years	5 years
Governor	1	Upon the recommendation of the County Executive.	2 years	5 years
Governor	2	Upon the recommendation of the majority leader of the County Legislature.	2 years	5 years
Governor	1	Upon the recommendation of the majority leader of the County Legislature.	4 years	5 years
Governor	1	Upon the recommendation of the minority leader of the County Legislature	2 years	5 years
Governor	1	Upon the recommendation of the Speaker of the Assembly	4 years	5 years
Governor	1	Upon the recommendation of the President Pro Tem of the Senate.	4 years	5 years
County Executive	3	N/A	2 years	5 years
County Legislature	4	N/A	3 years	5 years
Total	15			

In addition, the current enabling statute provides for three non-voting directors, including the Chief Executive Officer of NHCC, one director selected by the County Executive, and one selected by the County Legislature. The County Executive is given the authority to appoint one of the voting directors as Chairman of the Board. The Board of Directors is given the authority to select a chief executive officer "subject to the approval of the County Executive."

b. Recommended Governance Structure

The NHCC Board of Directors should continue to have fifteen members, however, the composition and appointment process should be changed as follows:

Appointing Person or Entity	Number	Recommendation	Initial Term	Subsequent Term
Ex Officio, with vote	5	Deputy County Executive County Commissioner of Health County Commissioner of Mental Health County Commissioner of Social Services NHCC CEO/President, approved by the County Executive	*	Conterminous with their official positions*
County Executive	5	Upon the recommendation of the County Legislature	3 Dir. - 1 year 2 Dir. - 2 years	3 years
County Executive	5	N/A	1 Dir. - 2 years 4 Dir. - 3 years	3 years
*Not subject to a particular term. Change would occur when new individuals hold the designated offices.				

The ex officio members are suggested to assure an appropriate interface between the County officials who have significant contributions to make regarding County health care policy and financial concerns related to the operation of NHCC. Ten members should be appointed by the County Executive, five of whom have been nominated by the County Legislature.

Qualifications of the ten members of the Board of Directors should be defined with more clarity than currently exists. Directors should be private citizens qualified by business or professional training and experience to oversee the affairs of a complex health care system and related enterprises, and should be broadly representative of the community. The CEO/President would serve at the pleasure of the Board of Directors. Removal, succession and related issues should be addressed in revised corporate By-Laws.

The current statute should be further amended to explicitly foreclose any County or NHCC employee from serving on the Board of Directors, other than the designated ex-officio members. Further, if employment with either the County or NHCC (or its subsidiaries) is obtained by any individual who was previously appointed to the Board, that individual must immediately resign from the Board. As noted below, among the recommended reserve powers of the County Executive, in consultation with the County Legislature, would be to remove the Board if it is deemed to be in the best interest of the County. A more complete discussion regarding the functioning of the Board of Directors is provided below.

c. Appointment Of A New Board

Pending adoption of the suggested statutory changes regarding restructuring of the governance of NHCC, the County Executive and the County Legislature and the State appointing authorities have the ability under the current statutory scheme to make direct appointments and nominations to particular Board positions, as vacancies and/or resignations occur. The NHCC Board of Directors thus could be re-constituted in accordance with our recommendations, to make it more responsive and accountable to local elected and appointed officials.

2. Financial Accountability

NHCC, by statute, should be made accountable and subject to audit by the County Comptroller. Currently, there is no specific statutory authority conferred on the County Comptroller to review, investigate and audit NHCC's financial affairs. It also should be noted that NIFA, pursuant to its enabling statute, has oversight responsibility over NHCC as a "covered organization." Consideration should be given to what additional definitions and/or clarifications should be made to NIFA's authority in relation to NHCC.

3. Other Statutory Changes

In addition to the statutory changes described above, we have listed by subject matter, a number of amendments that are recommended in order to permit NHCC to more effectively manage and operate its enterprises.

a. Personnel Administration; Civil Service:

(i) Creation of an internal Civil Service Commission is recommended. In New York State, public authorities are not subject to the Civil Service Law unless it is specifically provided in their enabling legislation. When Civil Service is made applicable to a public authority, the legislation can provide that administration of the public authority's civil service system can be subject to the public authority's own internal civil service commission, or to the New York State Civil Service Commission, or to the local municipal Civil Service Commission. We urge the creation of an internal Civil Service Commission for NHCC and its subsidiaries.

(ii) Creation of a true management tier of employees, as to which NHCC's Board and Administration would have the power to appoint, promote and remove, in accordance with appropriate business judgment.

(iii) All other employees should be administered consistent with the Civil Service Law, NHCC personnel rules and regulations, and applicable CSEA collective bargaining agreements.

b. Purchasing

(i) Permit NHCC and its subsidiaries to develop and promulgate appropriate policies governing the purchase of goods and services, including realistic competitive bidding requirements.

(ii) Explicitly permit NHCC participation in group purchasing programs.

c. Explicitly permit NHCC and its subsidiaries to enter into management and administrative services agreements, professional affiliations, joint ventures and other agreements.

d. Restrictions should be imposed on the use of proceeds of borrowings comparable to restrictions normally imposed in New York State Department of Health, Dormitory Authority of the State of New York, and Federal Housing and Urban Development Regulatory Agreements.

D. Obligations of NHCC's Governing Board.

In addition to the statutory changes related to the corporate restructuring outlined above, there are a number of additional findings and recommendations related to NHCC's governing body, the Board of Directors, that must be addressed.

1. Qualifications, Education and Orientation

The NHCC Board of Directors is responsible for governing a $485 million public benefit corporation, in the highly regulated and complex business of providing licensed hospital, nursing home and ambulatory health care services. However, there is no clear indication that the Board has been properly educated and oriented to their responsibilities as Board members of a New York State public authority that is also a health care provider. The requirements imposed on Board members of public authorities and licensed health care providers are formidable. They include obligations imposed by a broad variety of statutory, regulatory and accreditation requirements, including specifically:

a. Laws Applicable to New York Public Authorities Generally

(i) New York State Public Authorities Law

(ii) New York State Public Officers Law

(iii) New York State Not For Profit Corporation Law (which explicitly applies to public benefit corporations).

(iv) NHCC Statute

(v) New York State Labor Law

b. Laws Applicable to Healthcare Providers

(i) New York State Public Health Law

(ii) New York State Department of Health Regulations

(iii) Federal Medicare Statute, Regulations and Provider Agreement

(iv) Federal and State Medicaid Statute, Regulations and Provider Agreement

Collectively, this body of law seeks to define and impose standards of conduct and fiduciary duty, and very specific responsibilities with respect to assuring that critical oversight of each of the enterprises in fact occurs at the Board level. These critical oversight tasks include assessing and monitoring the quality of care provided, evaluating the key members of the administration, strategic planning, and approving responsible operating and capital budgets.

Excerpts from these various authorities regarding governing body responsibilities are included in Exhibit H.

In addition to the fiduciary duties traditionally imposed on directors of non-profit entities, there are evolving standards applicable to non-profit Boards, which invoke some of the Sarbanes Oxley standards of increased Board responsibility for independence and detailed oversight. See Peregine and Schwartz, "Taking the Prudent Path," Item 6 in Exhibit H.

In view of these complex and stringent duties, directors of NHCC and its subsidiaries must be provided with appropriate training and guidance, with respect to the rules governing Public Authorities generally, and health care providers, specifically.

2. NHCC's Corporate By-Laws Are Deficient

NHCC's By-Laws do not evidence that the Board of Directors historically has organized itself to provide the required consistent, in-depth oversight and direction for NHCC and its operating divisions. The By-Laws do not describe a committee structure normally found in a health care institution. The By-Laws provide for only one committee: an Executive Committee of three members. However, standard authorization for the Executive Committee to act for the corporation between meetings of the full Board, or when a quorum of the full Board is not achieved at a regularly scheduled meeting, is not included. Among the absent Board committees common to health care entities are:

Audit Committee
Finance Committee
Facilities Planning Committee
Development Committee
Quality Improvement Committee

The current Chairman has begun to remedy several of the historical limitations, pursuant to authority granted in the By-Laws. However, it does not appear that Board committees have yet been added to the By-Laws.

Finally, the By-laws do not contain any provisions concerning removal of directors and officers, or successorship. Appropriate provisions for removal of directors for defined cause should be adopted in conjunction with the restructuring of NHCC's governance.

3. Code of Ethics/Conflict Of Interest Policy

The NHCC Board of Directors has not adopted a Code of Ethics or a written disclosure policy oriented to NHCC's directors and officers There is a policy governing commercial arrangements applicable to physicians and employees.

In most public and not-for-profit corporations, including health care providers, a Code of Ethics or Conflicts Of Interest Policy has been adopted, to define appropriate standards of conduct for directors and officers. These policies generally include an obligation that disclosure forms be submitted to the entity annually, to assure that directors, officers and senior managers do not have undisclosed financial or other interests in transactions with the corporation. Policies then address the circumstances, if any, in which such interested-director transactions may be approved. These policies have been critical to compliance with applicable laws and regulations, and to monitoring and avoiding inappropriate outside interests which may be in conflict the

duties and responsibilities of directors and officers. While NHCC directors and senior managers may have submitted disclosure forms pursuant to Nassau County local law and/or pursuant to the New York State Public Officers law, it does not appear that such disclosures have been reviewed or used by NHCC internally to identify interested individuals as contracts and transactions are considered and approved.

Codes of Ethics and Conflicts of Interest policies also have the salutary effect of affirming that the entity's directors must function, first and foremost, as fiduciaries, and thereby combat perceptions, whether justified or not, that directors are more responsive to personal or political and partisan influences, rather than the entity's best interests.

E. Changes to the Administrative/Management structure of NHCC and its three divisions.

Healthcare provider organizations are extraordinarily complex and difficult organizations to manage and operate. Because of the nature of their patient care services, they are among the most regulated enterprises in the country. Every aspect of their organization, management, licensing, medical staff organization, physician arrangements, finance and reimbursement, facilities and equipment, and other components is regulated by federal, state and local regulatory agencies and accrediting bodies, which continuously measure and evaluate their compliance with required legal, ethical and business standards.

The individuals serving in the executive and management structure of healthcare providers must be qualified by their education, knowledge and experience to run these complex organizations. Ultimately, the responsibility for evaluating the performance of the CEO resides with the Board of Directors. In turn, the CEO must evaluate the individual members of the Senior Staff, including the Chiefs of Service of the Clinical Departments. However, there is a perception that, historically, external and internal politics have intruded in the selection and appointment of managers, as well as in their evaluation after appointment. In addition, the failure to develop a sound and realistic strategic business and financial plan for NHCC, coupled with the serious limitations described below, has engendered confusion and conflict as to the direction of the entire enterprise. It is recommended that the newly constituted Board promptly evaluate senior management in accordance with the factors discussed below. Any changes should be implemented in accordance with sound transition plans, to minimize disruption.

1. Table of Organization Generally

NHCC's administrative/management Table of Organization was reviewed to determine whether the current Table of Organization is properly structured to effectively manage NHCC and its three enterprises. As noted earlier, the President/Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Medical Officer, and senior staff members were interviewed. Each provided their candid views regarding the strengths and weaknesses within the administrative structure, and provided detailed descriptions of their views of the issues affecting NHCC generally, as well as concerns within their areas of responsibility. Their contribution to our understanding of NHCC is appreciated.

In reviewing the Table of Organization and in interviews with senior management, it became clear that limitations of skills and poor organization contribute to NHCC's dysfunction as an organization. The reporting relationships reflected in the Table of Organization are

fragmented and the span of responsibility and reporting relationships of individual executive managers are not organized by subject matters that should be grouped together substantively.

In addition, the long-term care and ambulatory care network enterprises are not appropriately integrated into the overall NHCC Table of Organization, and, as a result have been largely ignored by the administrative structure. Indeed, AHP has its own table of organization, which was found by the nursing home consultant to be illogical and splintered. Functional groupings are not maintained, and the AHP Table of Organization does not (separately or in combination with the NHCC table of organization) reflect the depth necessary to operate such a large facility. The regulatory requirement that the licensed nursing home administrator have a direct line of reporting to the governing board is not reflected in the AHP or NHCC Tables of Organization. The current use of an informal board committee to perform this function is insufficient.

Clear lines of reporting were not found in NHCC's splintered management structure, particularly where multiple senior managers have responsibility for parts of the same substantive area. Given the multiple reporting and approval lines, and perceptions that decisions can be overturned by outside and political influences, management decisions historically have languished without resolution, and without defined timeframes for implementation. Reorganization of the table of organization and other elements of NHCC's management structure would promote a disciplined, accountable approach to management, which in turn would foster better understanding of the objective rationales and justifications for management decisions.

2. Qualifications of Management

While the CEO has exhibited leadership qualities, his efforts have been made more difficult by the lack of a sound strategic plan, and by the limited depth of the senior and middle management supporting him. There are several senior and mid-level managers who have both technical expertise and experience commensurate with their positions. However, in interviews with NHCC's senior management, it became clear that the overall level of educational background and experience in health care management is low or non-existent. Many of the senior managers came to their positions from County positions, lack the required specific knowledge and experience, and have attempted to "learn on the job." This approach is particularly inappropriate in a health care organization that is in serious financial trouble and must deal with the complex and critical patient care, regulatory, compliance and financial issues faced by NHCC. While evaluation of individual managers was beyond the scope of this study, the new Board should undertake such evaluations as soon as possible.

The medical staff leadership also should be considered managers. While generally qualified in their respective clinical disciplines, NHCC's medical staff leadership do not have management training and do not have the necessary skill set required to analyze and develop plans addressing the important strategic business and financial considerations with respect to operation, management and staffing of their departments. Generally speaking, they have pursued their personal and department's provincial interests over those of the institution as a whole.

3. Lack Of A Management Tier

Among the most severe flaws in the structure of NHCC is the lack of a management tier of employees. As a consequence of arcane and an abberational history related to the absence of a management compensation and benefit plan and the compression of the County's salary

structure, key managers, including mid-level managers who have significant budgetary and managerial decision-making authority, are included in the collective bargaining unit represented by CSEA. Sound management decisions are adversely impacted by this anomaly. As discussed above, a statutory change to permit the creation of a management tier has been recommended.

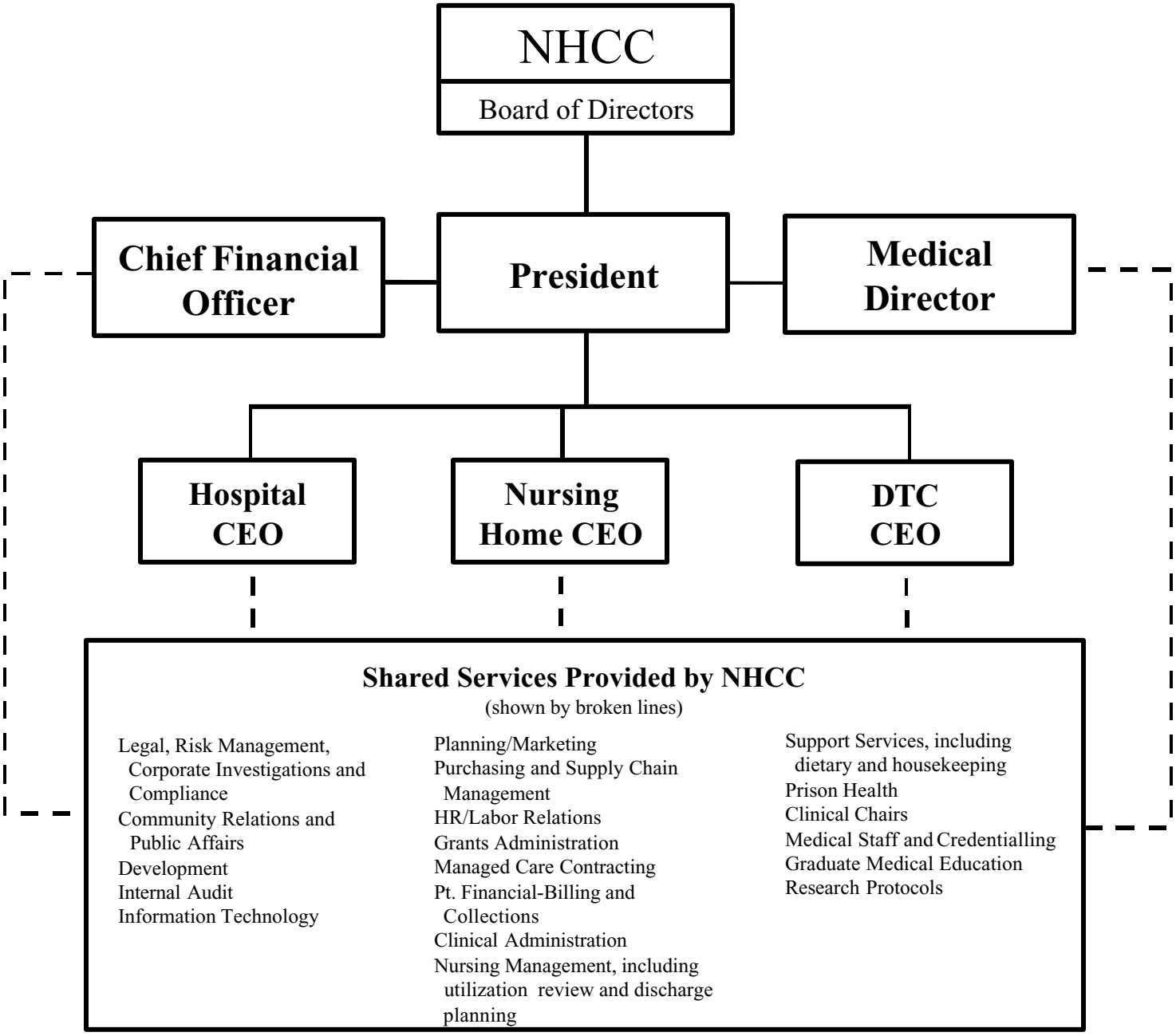
A review of job titles should be undertaken to specifically define which titles should be placed in the management tier. Pending adoption of the statutory changes, NHCC should develop and adopt a management compensation and benefits plan, create detailed job descriptions specifying education and experience requirements for each management position, and seek Public Employment Relations Board approval to remove these positions from inclusion in the bargaining unit.

4. Proposed Revisions To Administrative Structure

This is not intended to be an academic discussion of organizational theory. Every organizational chart has its limitations. It is, however, a suggested structure regarding how NHCC's management should be organized to provide a cohesive management tier with clear areas of responsibility and reporting among its members, and the basis upon which managers can be held accountable.

The table below provides a schematic diagram of the recommended inter-relation of management among NHCC and the proposed hospital, nursing home and ambulatory care network subsidiaries. Once the basic structure is in place, detailed tables of organization should be created by functional subject matter groupings, reporting as indicated in the diagram.

The recommended administrative structure provides for each subsidiary to have a dedicated Chief Executive Officer, who would report to the subsidiary's Board of Directors, and to the NHCC President. The Chief Financial Officer and Medical Director functions would be provided by NHCC through a "shared services" arrangement, i.e. services organized centrally and provided to each Enterprise/subsidiary pursuant to a shared services agreement. Other services to be provided through a shared services arrangement are shown on the diagram below.


NHCC
Board of Directors
Chief Financial Officer
President
Medical Director
Hospital CEO
Nursing Home CEO
DTC CEO
Shared Services Provided by NHCC
(shown by broken lines)
Legal, Risk Management, Corporate Investigations and Compliance
Community Relations and Public Affairs
Development
Internal Audit
Information Technology
Planning/Marketing
Purchasing and Supply Chain Management
HR/Labor Relations
Grants Administration
Managed Care Contracting
Pt. Financial-Billing and Collections
Clinical Administration
Nursing Management, including utilization review and discharge planning
Support Services, including dietary and housekeeping
Prison Health
Clinical Chairs
Medical Staff and Credentialling
Graduate Medical Education
Research Protocols